

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14241

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14246

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 5021 Laguna Road	
3. NAME OF DECEASED (Type or print) First Middle Last William J Adams		4. DATE OF DEATH Month Day Year 10 31 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Feb. 1896
9. AGE (In years last birthday) yrs. 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST	
11. BIRTHPLACE (State or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME NOAH ADAMS		14. MOTHER'S MAIDEN NAME LAURA WESTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 241 14 3393	
17. INFORMANT RALPH M. MOORE		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - over 1 year.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-31-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery	23d. LOCATION (City or Town) (County) (State) CHARLOTTESVILLE VIRGINIA
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. RIVERDALE, MD.		25a. REC'D BY REGISTRAR NOV 3 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14242

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14247

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Hyattsville	
3. NAME OF DECEASED (Type or print) First Middle Last Ray E Anderson		4. DATE OF DEATH Month Day Year 10 8 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 April 1911
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY carpenter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Lee Anderson sr		14. MOTHER'S MAIDEN NAME Bessie Edwards	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 225 05 1653	
17. INFORMANT Evelyn Mae Anderson		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 148X DUE TO Carcinoma of the pharynx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH over 2 yrs over 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 10-9-67	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 11, 1967	
23c. NAME OF CEMETERY OR CREMATOR Washington National		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE OCT 11 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5805 Ravenswood Road	
3. NAME OF DECEASED (Type or print) First Mary Middle L Last Bakersmith		4. DATE OF DEATH Month Oct. Day 15 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Sept., 1924
9. AGE (In years lost birthday) yrs. 43		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME RALPH KARNES		14. MOTHER'S MAIDEN NAME VINNA BENSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 443261303	
17. INFORMANT ALOUISE PICKERAL		Address S	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary heart failure DUE TO (c) Pneumonia		Acute pulmonary edema, severe INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Lupus erythematosus; Disfiguring scellitis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from Oct. 13, 19 67 , to Oct. 15, 19 67 , that (x) (we) last saw the deceased alive on Oct. 15, 19 67 , and that death occurred at 2.05 AM from causes and on the date stated above.			
22a. SIGNATURE Fidel J. Quintana		22b. DATE SIGNED Oct. 15, 1967	
22c. PHYSICIAN'S NAME (Type) Fidel J. Quintana, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION (City or Town) (County) (State) CEM BLADENSBURG, MARYLAND	
24. FUNERAL DIRECTOR W.W. Chambers Co. RIVERDALE, MD		25a. REC'D BY REGISTRAR OCT 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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Winton George General Hospital

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

14244

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-800. 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 45 min. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 5713 Jay Street	
3. NAME OF DECEASED (Type or print) First Vernon Middle W Last Barnett		4. DATE OF DEATH Month 10 Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 April 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver Confection		9. AGE (In years lost birthday) 56 yrs.	11. BIRTHPLACE (State or foreign country) Kentucky
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vernon W Barnett Sr		14. MOTHER'S MAIDEN NAME Rosa Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW2		16. SOCIAL SECURITY NO. 579-01-5706	
17. INFORMANT Mrs Dorothy B White		Address 29-42nd St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebro vascular accident DUE TO Hypertensive cerebro vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH over 1 hr. unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-31-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-3-1967	23c. NAME OF CEMETERY OR CREMATORY Harmony	23d. LOCATION (City or Town) (County) (State) Highland Park Md
24. FUNERAL DIRECTOR H.S. Washington & Sons		25a. REC'D BY REGISTRAR NOV 3 1967	
ADDRESS 4925 Deane Avenue		25b. REGISTRAR'S SIGNATURE Charles Judge	

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are faintly visible.]

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cherryland</i>		c. LENGTH OF STAY IN <i>8 dys</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>6915 Carleton Terrace</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Pr Geo Gen Hospital</i>		d. STREET ADDRESS <i>College Park</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>FRANCES M BAUER</i>		4. DATE OF DEATH <i>Oct 15 1967</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 29, 1888</i>
9. AGE (In years, months, days) <i>79 yrs.</i>		10. IF UNDER 1 YEAR: Months <i>15</i> Days <i>15</i> Hours <i>67</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>WILLIAM J. BARNARD</i>		14. MOTHER'S MAIDEN NAME <i>UNK - HEWITT</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>John W Bauer (husband)</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO (b) <i>Hypertensive/arteriosclerosis</i> DUE TO (c) <i>Cerebral Vascular Disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary atherosclerotic heart disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10-6-67</i> , to <i>Oct 15 67</i> , that (I) (we) last saw the deceased alive on <i>10-14 1967</i> , and that death occurred at <i>12 M</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>W. L. Etienne</i>		22b. DATE SIGNED <i>10-15-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. L. Etienne</i>		22d. ADDRESS <i>College Park, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>Oct 18, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>ASBURY CEM</i>	23d. LOCATION (City or Town) (County) (State) <i>PERRYVILLE MARYLAND</i>
24. FUNERAL DIRECTOR <i>W. W. CHAMBERS Co RIVERDALE, MD</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>OCT 18 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14390

CERTIFICATE OF DEATH

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OCT 14 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14246				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14251			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 12 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights d. STREET ADDRESS 2506 Iverson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Edward T. Beach				4. DATE OF DEATH Month Day Year Oct. 12, 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/27/13		9. AGE (In years last birthday) yrs. 54		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN BENTONS REALTY				10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON D.C.				11. BIRTHPLACE (County & State, or foreign country) U.S.			
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME EDWARD W. BEACH				14. MOTHER'S MAIDEN NAME SARAH BURNETT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 578-16-6638				17. INFORMANT EMILIO TAVAROZA Address 6012 NAVAL AV LANHAM, MD. 20801			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cerebral atherosclerosis DUE TO Stenosing arteriosclerosis of the coronary arteries (c) Generalized atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 29, 1967 , to Oct. 12, 1967 , that (I) (was) saw the deceased alive on Oct. 12, 1967 , and that death occurred at 11:10 PM , from causes and on the date stated above.											
22a. SIGNATURE Fidel J. Quintana				22b. DATE SIGNED Oct 18 1967							
22c. PHYSICIAN'S NAME (Type) Fidel Quintana, M. D.				22d. ADDRESS Prince Georges General Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct 16, 1967		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND					
24. FUNERAL DIRECTOR W.W. CHAMBERS, Co. RIVERDALE MD				25a. REC'D BY REGISTRAR OCT 18 1967		25b. REGISTRAR'S SIGNATURE O. Chambers, Judge					

1-25-51

DATE OF DEATH

1-25-51

Place of Birth

Place of Birth

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jwb
VR A15 (4)
15M 4-64

Medical Examiner Dr John Kehoe Pro Geo County Md notified and approved

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
14247									
14252									
1. PLACE OF DEATH a. COUNTY <u>Prince George's County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>				
c. LENGTH OF STAY IN 1b <u>25 years</u>					d. STREET ADDRESS <u>8 M Southway Road</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8 M Southway Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Adelina</u> Middle <u>Marie</u> Last <u>Beck</u>					4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 6, 1910</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Snyder, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
13. FATHER'S NAME <u>Enrico Barili</u>					14. MOTHER'S MAIDEN NAME <u>Kate Trutt</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Husband and mother</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO (b) <u>Metastatic Carcinosarcoma</u> DUE TO (c) <u>Carcinosarcoma of uterus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>3 years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>September 1967</u> , to <u>October 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>October 18, 1967</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert S. Wilkinson</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>October 28, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert S. Wilkinson, M.D.</u>					22d. ADDRESS <u>2121 Pennsylvania Ave. N.W. Washington DC 20037</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10/31/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Selinsgrove Pa.</u>		
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>					ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>Oct 31 1967</u>		
							25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>		

1952

June 1952

July 1952

August 1952

September 1952

October 1952

November 1952

December 1952

January 1953

February 1953

March 1953

April 1953

May 1953

June 1953

July 1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14248		CERTIFICATE OF DEATH	
14253			
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b Hyattsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Iphigenia		4. DATE OF DEATH Month Oct. Day 24, Year 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1872	
9. AGE (In years last birthday) 95 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Young		14. MOTHER'S MAIDEN NAME Martha Ritchie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. --	
17. INFORMANT Margaret Beller		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 490X DUE TO (b) Bilateral Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mins 14 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 10, 1967, to Oct. 24, 1967, that (I) (we) last saw the deceased alive on Oct. 24, 1967, and that death occurred at 4:45 P.M., from causes and on the date stated above.			
22a. SIGNATURE Charles C. Hageage		22b. DATE SIGNED Oct. 24, 1967	
22c. PHYSICIAN'S NAME (Type) Charles C Hageage		22d. ADDRESS Mt Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro George Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR OCT 30 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

1-23-51

CERTIFICATE OF DEATH

1-23-51

Place of Birth

Age at Death

Place of Death

Date of Death

Time of Death

Cause of Death

Medical History

Attending Physician

Place of Death

Time of Death

Signature of Physician

Signature of Registrar

Signature of Witness

Signature of Coroner

Signature of Jury

Signature of Judge

Signature of Clerk

Signature of Sheriff

Signature of Constable

Signature of Notary

1-23-51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

14248				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14254			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b D.O.A.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE GENERAL HOSPITAL				d. STREET ADDRESS 5000 Queensbury Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hanawalt First Middle Last E Bennett				4. DATE OF DEATH OCT 16 1967 Month Day Year							
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 24, 1901		9. AGE (In years lost birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired stock Clerk				10b. KIND OF BUSINESS OR INDUSTRY Gas Light co				11. BIRTHPLACE (County & State, or foreign country) Kentucky			
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Loyal P Bennett				14. MOTHER'S MAIDEN NAME Ida M. Simmons			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214 01 0267				17. INFORMANT Address Doris R Bennett Riverdale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HT FAILURE DUE TO (b) BIL BRONCHO PNEUMONIA DUE TO (c) CARCINOMATOSIS - BRONCHIOGENIC CARCINOMA										INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20 ANEMIA										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1960 , to OCT 1967 , that (I) (we) last saw the deceased alive on OCT 9 1967 , and that death occurred at 11 A M, from causes and on the date stated above.											
22a. SIGNATURE Benjamin S. Miller				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Benjamin S. Miller				22d. ADDRESS Mt Rainer, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR OCT 19 1967				25b. REGISTRAR'S SIGNATURE J Charles Judge			

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14250

14255

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 709 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna L. Bergy		4. DATE OF DEATH Month 10 Day 20 Year 19 67	
5. SEX XXXX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/88
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (County & State, or foreign country) Lacy Springs, Rockingham, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph K. Summers		14. MOTHER'S MAIDEN NAME Margaret Virginia Earman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no - - -		16. SOCIAL SECURITY NO. 946-71-0016	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism, clinical DUE TO (b) DUE TO (c) Carcinoma, right kidney, resected		INTERVAL BETWEEN ONSET AND DEATH sudden 8 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis, moderately advanced		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from 11/9/19 65 to 10/20/19 67, that (X) (we) last saw the deceased alive on 10/20/19 67, and that death occurred at 3:00P M, from causes on and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 10/20/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-23-67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	23d. LOCATION (City or town) (County) (State) WASHINGTON, D.C.
24. FUNERAL DIRECTOR LEWIS FUNERAL HOME		25a. REC'D BY CLERK DATE OCT 24 1967	

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UNITED STATES

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UNITED STATES

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UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14251		Item #9 Film #0393 10/5/67 ph		14256	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 47.3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN lb 4 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1926 11th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mattie		First Middle Last Blow		4. DATE OF DEATH Month Day Year October 1, 1967	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/04		9. AGE (In years last birthday) 63 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) N.C.	
13. FATHER'S NAME unknown		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT decedent Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia (10 days) with super-imposed pulmonary embolism DUE TO (b) (thrombosis inferior vena cava) DUE TO (c) Fracture of the odontoid process with resultant quadriplegia				INTERVAL BETWEEN ONSET AND DEATH unknown 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Focal encephalomalacia				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/31/1967 to 10/1/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/1/1967 , and that death occurred at 10:06 PM from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/1/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial	
23d. LOCATION (City or Town) (County) (State) Prince Geo. County, Md.		24. FUNERAL DIRECTOR Watneys Funeral Home, 3831 - Ga., Ave., S.W. Wash. D.C.			
25a. REC'D BY REGISTRAR 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

Given Date (year)

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14257

14252

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AFB</u> c. LENGTH OF STAY IN 1b <u>106 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MALCOLM GROW USAF HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>FAIRFAX</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALEXANDRIA</u> d. STREET ADDRESS <u>457 ARGYLE AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BERTHA MASON BOATNER</u>			4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>30</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Jan 1910</u>		9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (State or foreign country) <u>NEW ORLEANS, LA.</u>			
13. FATHER'S NAME <u>JACOB ALLEN GORMAN</u>			14. MOTHER'S MAIDEN NAME <u>EDITH PEAKE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NA</u>		16. SOCIAL SECURITY NO. <u>302-40-8212</u>		17. INFORMANT <u>HUSBAND</u> Address <u>SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Brain tumor (Glorbescence multiforme)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 month</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, <u> </u> Day, <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>17 Jul 1967</u> to <u>30 Oct 1967</u> that (I) (we) last saw the deceased alive on <u>30 Oct 1967</u> and that death occurred at <u>1149</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert J. Wilkus MD</u> M.D.				22b. DATE SIGNED <u>30 Oct 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT J. WILKUS, CAPT, USAF MC</u>				22d. ADDRESS <u>Malcolm Grow USAF Hospital Andrews AFB, Wash DC 20331</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-1-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arl. National Cemetery</u>			
23d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>Emory-Wheatley Funeral Home</u> ADDRESS <u>Alex., Va.</u>			
25a. REC'D BY REGISTRAR DATE <u>NOV 2 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11301

CERTIFICATE OF DEATH

11301

11301

CHIEF CLERK

11-1-11

NOV 2 1911

11-1-11

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14253

CERTIFICATE OF DEATH

14258

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY -----	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAM Middle BORAK Last BORAK		4. DATE OF DEATH Month October Day 16 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1895
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Merchant	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Saul Barak		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-32-2082 A	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X DUE TO (b) CARDIAC ARREST DUE TO PNEUMONITIS DUE TO (c) & ARTERIOSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH 4-5 DAYS YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from NOV. 10, 1959 to 15 OCT. 1967 , that (I) (we) last saw the deceased alive on 15 OCT. 1967 , and that death occurred 12:34 M, from causes and on the date stated above.			
22a. SIGNATURE Henry R. Wolfe		22b. DATE SIGNED 10-16-1967	
22c. PHYSICIAN'S NAME (Type) Henry R. Wolfe, M.D.		22d. ADDRESS 905 Sheridan Street Chillum Terrace, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-17-67	23c. NAME OF CEMETERY OR CREMATORY Beth Sholom Cemetery	23d. LOCATION (City or Town) (County) (State) Capitol Heights Md.
24. FUNERAL DIRECTOR Goldberg Funeral Home		25a. REC'D BY REGISTRAR OCT 20 1967	
ADDRESS 4217 9th St., N.W.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

222

CERTIFICATE OF DEATH

14259

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1923 Bel Haven Drive #201 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary E. Bowling				4. DATE OF DEATH Month Day Year Oct. 18, 1967			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1901 2/25/1900		9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Edward Douglas				14. MOTHER'S MAIDEN NAME Matilda M. Berry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Zelda S. Clark - 1923 Belle Haven Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Severe stenosing coronary arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from Oct. 10, 1967 to Oct. 18, 1967 , that (H) (we) last saw the deceased alive on Oct. 18, 1967 , and that death occurred at 8:50AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Fidel J. Quintana</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Fidel Quintana, M. D.				22d. ADDRESS Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-24-67		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION (City or Town) (County) (State) Prince George, Maryland	
24. FUNERAL DIRECTOR Prince Funeral Home 3015 12th St				25a. REC'D BY REGISTRAR DATE OCT 23 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14255

CERTIFICATE OF DEATH

14260

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meadows, Md. Upper Marlboro	
c. LENGTH OF STAY IN 1b 3 days		d. STREET ADDRESS R F D Box 4276	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isabelle Middle Almira Last Bradburn		4. DATE OF DEATH Month Oct. Day 1 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Sept., 1890
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Beavers		14. MOTHER'S MAIDEN NAME Annie Augherton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) W.W.I		16. SOCIAL SECURITY NO. --	
17. INFORMANT 723 14th St., N.W. Eleanor B. Sewell-Albuquerque, N.M.		18. INTERVAL BETWEEN ONSET AND DEATH 1 week	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopneumony and Stomach 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thrombosis DUE TO (c) Hypertensive intracerebral hemorrhage. Anemia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-28-67 , 19 67 , to 10-1-67 , that (I) (we) last saw the deceased alive on 9-30-67 , 19 67 , and that death occurred at 1.00AM , from causes and on the date stated above.			
22a. SIGNATURE Oliver B. Bond		22b. DATE SIGNED 10-1-67	
22c. PHYSICIAN'S NAME (Type) Oliver B. Bond, M.D.		22d. ADDRESS 6872 RIVERDALE RD LANHAM MD 20801	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/4/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Bladensburg Md.
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR OCT 4 1967	25b. REGISTRAR'S SIGNATURE Charles J. Jones

1-1280

MINUTE OF DEED

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the ward "pending" in pencil in Item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14261

14256

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>6816 Redtop Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cecelia Agnes Brady</u>				4. DATE OF DEATH Month Day Year <u>10 26 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>18 Oct. 1920</u>		9. AGE (In years lost birthday) <u>47</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>THE HECHT CO.</u>		11. BIRTHPLACE (State or foreign country) <u>LONG ISLAND NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>JOHN O'MALLEY</u>				14. MOTHER'S MAIDEN NAME <u>DELIA McDONOUGH</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>FRANK M. O'MALLEY DALTON, PENNA.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u> DUE TO <u>Cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>over 4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				22. DATE SIGNED <u>10-27-67</u>			
EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Oct. 31, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>QUEENS COUNTY, NEW YORK</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS 60 RIVERDALE, MD</u>				25a. REC'D BY REGISTRAR <u>NOV 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

14288



NOV 1 1951

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14257

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14262

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 48 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 4202 72nd. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Albert H Braund			4. DATE OF DEATH Month Day Year 10 27 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-1905	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEET METAL WORKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DISTRICT OF COLUMBIA	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME UNKNOWN BRAUND		
14. MOTHER'S MAIDEN NAME UNKNOWN			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		
16. SOCIAL SECURITY NO. 578037194			17. INFORMANT MRS. BERTHA M. BRAUND, SAMEAS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 9160 DUE TO 3rd. degree burns of both legs (20% of body) 48 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gasoline spilled on pants which caught fire.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1:00pm 9-10- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) same as #2		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 10-27-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct 30, 1967		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM	
23d. LOCATION (City or town) COLMAR MANOR, MARYLAND		(County)		(State)	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, Md.		ADDRESS		25a. REC'D BY REGISTRAR NOV 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14263

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mt. District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Clinton)		c. LENGTH OF STAY IN 1b Driving Thru	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Rt. 5 nr Surrats Rd.		d. STREET ADDRESS 660 Independence Ave., S.E.	
3. NAME OF DECEASED (Type or print) George Fred Bremier		4. DATE OF DEATH Month 10 Day 14 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Sept 1932
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 14 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mathematician		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George L. Bremier		14. MOTHER'S MAIDEN NAME Margaret Krosenic	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Bremier		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns 100% of body surface DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:20pm 8 14 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. Rt. 5 Clinton P.G. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-15067	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/17/67	
23c. NAME OF CEMETERY OR CREMATORY Washington Natl. Cem. Suitland Pr. Geo. Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR J. Wm. Lees Sons, 300 4th St., NE, Wash. DC		25a. REC'D BY REGISTRAR OCT 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

3631

1026

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15793

14253

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS General Delivery e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Bryce		4. DATE OF DEATH Month Day Year Oct. 26, 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1967
9. AGE (In years lost birth day) yrs. 23		10. IF UNDER 24 HRS. Months Days Hours Min. 23 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wells Colbert		14. MOTHER'S MAIDEN NAME Barbara Ann Bryce	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7625 IMMEDIATE CAUSE (a) prematurity DUE TO (b) Atelectasis of lungs. bilateral DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Oct. 25, 1967 , to Oct. 26, 1967 , that he (we) lost saw the deceased alive on Oct. 26, 1967 , and that death occurred at 4:15 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Hugh Clark</i>		22b. DATE SIGNED 10/27/67	
22c. PHYSICIAN'S NAME (Type) Hugh Clark, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11-11-67.		23b. DATE THEREOF 11-11-67.	
23c. NAME OF CEMETERY OR CREMATORY Prince George's General		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR William A. Parker, Cheverly, MD.		25a. REC'D BY REGISTRAR NOV 14 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

VR A15 (4)
25M 1/67

7-280316

1955

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1955

Prince George's General Hospital

Classified

1 day

Prince George's General Hospital

General Delivery

Prince George's General Hospital

Male

Oct. 22, 1955

John White College

Prince George's General Hospital

Prince George's General Hospital

Oct. 16, 1955

Oct. 22, 1955

Oct. 22, 1955

NOT RECORDED

John White College

Prince George's General Hospital

11-1-57 Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

Prince George's General Hospital

13-Wa 7-552-1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18, 21 film 398
3-7-68 mt
14260
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14264

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs 16.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 6009 Allentown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Evelyn Middle Elizabeth Last Buckler			4. DATE OF DEATH Month 10 Day 26 Year 19 67		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-14		9. AGE (In years lost birthday) yrs. 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Walter J. Ogden		
14. MOTHER'S MAIDEN NAME Alice M. Day			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Helen V. McDonald (Sister) # 2.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intoxication-ethyl alcohol 3222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 10-28-67		23. LOCATION (City or Town) (County) (State) Clinton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 30-1967		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	
24. FUNERAL DIRECTOR Simmons Bros.		ADDRESS 1661- Good Hope Rd., SE. Wash., DC		25a. REC'D BY REGISTRAR OCT 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 3mos., 24days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital, Glenn Dale, Md.		d. STREET ADDRESS 5021 Ayers Pl., S. E.	
3. NAME OF DECEASED (Type or print) Alice K. Bundy		4. DATE OF DEATH Month 10 Day 27 Year 19 67	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/1898
9. AGE (In years lost birthday) yrs. 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charlie Smith		14. MOTHER'S MAIDEN NAME Frances Parker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-26-2268	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RENAL FAILURE DUE TO (b) CHRONIC RENAL FAILURE DUE TO (c) ARTERIOULAR NEPHRO-SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 7 DAYS MANY YEARS MANY YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE (2) ARTERIO-SCLEROTIC H. DIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/3/ , 19 67 , to 10/27/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/27/ 19 67 , and that death occurred at 1:45P M, from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 10/27/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11-1-67	23c. NAME OF CEMETERY OR CREMATORY Church Cemetery Culpper VA.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Therese Williams		25a. REC'D BY REGISTRAR 3435 19 67	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 31 1967	

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1-1565

Prince George

B. C.

Glenn Dale (Ward) James, George

Washington

Glenn Dale Hospital, Glenn Dale, Md.

5051 Avenue H, S. E.

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Samuel

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Charles Smith

Francis Smith

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Doc. Walter, R. D.

Glenn Dale Hospital, Glenn Dale, Md.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delays are necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

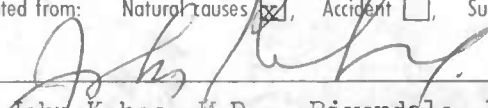
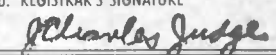
VR A15ME (5)
6M 1/67

14262

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14266

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5507 Sargent Road				d. STREET ADDRESS 5507 Sargent Road			
3. NAME OF DECEASED (Type or print) Mary M Burgess				4. DATE OF DEATH Month 10 Day 30 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-1886	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Hornback				14. MOTHER'S MAIDEN NAME Amelia Veidt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Lucile Sanchez		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease minutes unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus - over 5 yrs.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF DEATH Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 10-30-67
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Kehoe, M.D.		M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) Washington D. C		(County) (State)	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 1 1967	25b. REGISTRAR'S SIGNATURE 

1280

1-28-60

A MEDICAL EXAMINATION REPORT OF A PATIENT

NAME: [illegible] DOB: [illegible] SEX: [illegible] RACE: [illegible]

DATE OF EXAMINATION: [illegible] TIME: [illegible] LOCATION: [illegible]

PHYSICIAN: [illegible] NURSE: [illegible] ASSISTANT: [illegible]

REASON FOR EXAMINATION: [illegible]

GENERAL APPEARANCE: [illegible]

VITAL SIGNS: [illegible]

HEENT: [illegible]

HEART: [illegible]

LUNGS: [illegible]

ABDOMEN: [illegible]

EXTREMITIES: [illegible]

NEUROLOGIC: [illegible]

PSYCHIATRIC: [illegible]

LABORATORY: [illegible]

IMPRESSION: [illegible]

RECOMMENDATION: [illegible]

SIGNATURE: [illegible]

NOV 1 1960

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14267

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital		d. STREET ADDRESS 5393 Quincy St.	
3. NAME OF DECEASED (Type or print) Kenneth Earl Canterbury		4. DATE OF DEATH Month 10 Day 22 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 April 1923
9. AGE (In years lost birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Benjamin Canterbury		14. MOTHER'S MAIDEN NAME Alla Alliff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Edna L Canterbury		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) over 1 yr.			INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-22-67	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Huse Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Fayetteville W.Va.
24. FUNERAL DIRECTOR F. Gasch & Sons, Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1137

1138

1137

1138

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14264

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14268

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1102 69th. Avenue	
3. NAME OF DECEASED (Type or print) Jerry Jeremiah Franklin Chapman		4. DATE OF DEATH 10 25 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 July 1909
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Jerry J. Chapman		14. MOTHER'S MAIDEN NAME Mary Chittoms	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mary Chapman Same as 2D		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 463X DUE TO Thrombophlebitis of left leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH minutes over 10 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema - over 10 months			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-26-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-28-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City or Town) (County) (State) Highland Park Md	
24. FUNERAL DIRECTOR H.S. Washington & Sons		25a. REC'D BY REGISTRAR 4925 Deane Ave	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 31 1967	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

14265

14269

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William J. Claspell Sr.		4. DATE OF DEATH Month 10 Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 June 1894
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engr.	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William J. Claspell		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes give war or dates of service) 678 01 4112		16. SOCIAL SECURITY NO. 678 01 4112	
17. INFORMANT Florence E. Claspell		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease over 2 wks. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-30-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		23. LOCATION (City or Town) (County) (State) Suitland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 31-1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. ADDRESS Simmons Bros. 1661-Good Hope Rd SE Wash DC
24. FUNERAL DIRECTOR Simmons Bros.		25. REC'D BY REGISTRAR NOV 1 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1961

1961

1961

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14266

CERTIFICATE OF DEATH

14270

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Glenn Dale)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>5 mo. 10 days</u>		d. STREET ADDRESS <u>1616 17th Place, S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenn Dale Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Thomas Clayton</u> First Middle Last		4. DATE OF DEATH <u>Oct. 21</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1891</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown DISPATCHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONCRETE Co</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Clayton</u>		14. MOTHER'S MAIDEN NAME <u>M. Frances Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-5611</u>	
17. INFORMANT <u>Hadley Hospital</u>		Address <u>Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>cerebrovascular accident with right hemiparesis</u> years (c) <u>hypertensive and arteriosclerotic cardiovascular disease</u> unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema and fibrosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>67</u> , to <u>10/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/21</u> 19 <u>67</u> , and that death occurred at <u>8:00 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Moe Weiss</u>		22b. DATE SIGNED <u>Oct. 21, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Moe Weiss, M.D.</u>		22d. ADDRESS <u>Glenn Dale Hospital, Glenn Dale, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>OCT. 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG MD.</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. 5801 Cleveland Ave</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 1 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

6092

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Page 40

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>7</div> <div>1</div> </div> <div> <div>Items 18, 20, 21 film 397</div> <div>2-15-68 mt</div> </div> <div> <div>14267</div> <div>14271</div> </div> </div> <div> <div>FOR STATE HEALTH DEPT</div> <div> <div>1</div> <div>1</div> </div> </div> <div> <div>14267</div> <div>14271</div> </div>												<div> <div> <div>1</div> <div>1</div> </div> <div> <div>1</div> <div>1</div> </div> </div> <div> <div>1</div> <div>1</div> </div>											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wooded area off Bell Station Road						d. STREET ADDRESS Bell Station Road																	
3. NAME OF DECEASED (Type or print) Carrie Elizabeth Conwell						4. DATE OF DEATH Month 10 Day 30 Year 1967																	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-1936		9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months 30 Days 19 Hours 67 Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Glenn Dale, Md.															
13. FATHER'S NAME Cleveland Beall						12. CITIZEN OF WHAT COUNTRY? U S A																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no						16. SOCIAL SECURITY NO. 220 32 5348		17. INFORMANT O E Conwell Jr Address Lanham, Md.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 9328 Intoxication Doriden IMMEDIATE CAUSE (a) 9328 DUE TO (b) Exposure to cold DUE TO (c) 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Froze while in woods after overdose of Doriden																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Froze while in woods after overdose of Doriden																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10-26-67 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) (County) (State) Lanham PG Md															
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE John Kehoe, M.D.						22. DATE SIGNED 10-31-67																	
EXAMINER'S NAME (Type) John Kehoe, M.D.						Address (Street, city, town, or county) Riverdale, Md.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov 3, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Georges Md.													
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE NOV 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge															

1944

1944

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR CREDIT

WASHINGTON, D. C.

REPORT OF THE ASSISTANT SECRETARY FOR CREDIT

FOR THE YEAR 1944

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CHAPTER XXIX. THE CREDIT MARKET

CHAPTER XXX. THE CREDIT MARKET

CHAPTER XXXI. THE CREDIT MARKET

CHAPTER XXXII. THE CREDIT MARKET

CHAPTER XXXIII. THE CREDIT MARKET

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CHAPTER XXXVI. THE CREDIT MARKET

CHAPTER XXXVII. THE CREDIT MARKET

CHAPTER XXXVIII. THE CREDIT MARKET

CHAPTER XXXIX. THE CREDIT MARKET

CHAPTER XL. THE CREDIT MARKET

CHAPTER XLI. THE CREDIT MARKET

CHAPTER XLII. THE CREDIT MARKET

14269

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

142'72

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 33 Maryland Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Dorothy Corker		4. DATE OF DEATH 10 1 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 Jan. 1913 9. AGE (In years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Government		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Edward Boniface		14. MOTHER'S MAIDEN NAME Margaret Madden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Joan Komatsoulis		Address Upper Marlboro 11002 Phillip Dr. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH minutes over 1 year
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/4/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges, Md
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR OCT 6 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14268

14273

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b five days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 6118 62nd Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Homer Warren Corso			4. DATE OF DEATH Month Day Year 10 27 19 67		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-18		9. AGE (In years last birthday) yrs. 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired claim examiner		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Washington D. C.	
13. FATHER'S NAME Andrew Corso			12. CITIZEN OF WHAT COUNTRY? U S A		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 221 07 8413		17. INFORMANT Dorothy Corso Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral embolus DUE TO (c) Mural thrombus of left ventricle					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) overdose of Doriden					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) took overdose of Doriden at home			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 8:00pm 10-22 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Riverdale P.G. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		M.D. John Kehoe		22. DATE SIGNED 10-28-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 30, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		23d. LOCATION (City or town) (County) (State) Colmar Manor Pro Geo Md.	
25a. REC'D BY REGISTRAR DATE OCT 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

11/11/51

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14270		CERTIFICATE OF DEATH	
14274			
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY MARYLAND PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRADBURY HEIGHTS 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL		d. STREET ADDRESS 5110 S STREET S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last MAURIECE EUGENE COX		4. DATE OF DEATH Month Day Year OCTOBER 27 19 67	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Nov 30
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF		10b. KIND OF BUSINESS OR INDUSTRY USAF	
11. BIRTHPLACE (County & State, or foreign country) RED STAR, W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH ALEXANDER COX		14. MOTHER'S MAIDEN NAME NELLIE FAY GRIMETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 236-44-4586	
17. INFORMANT WIFE		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 26 Oct, 1967, to 27 Oct, 19 67 that (X) (we) last saw the deceased alive on 27 Oct 67 19, and that death occurred at 12:03 AM, from causes and on the date stated above.			
22a. SIGNATURE Louis G. Martin		22b. DATE SIGNED 27 Oct 67	
22c. PHYSICIAN'S NAME (Type) LOUIS G. MARTIN, CAPT, USAF, MC		22d. ADDRESS Malcolm Grow USAF Hospital Andrews AFB, Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-31-67	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Falls Church Funeral Home, Falls Church, Va.		25a. REC'D BY REGISTRAR DATE OCT 31 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 10-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14271

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

142'75

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 4906 Taylor Road	
3. NAME OF DECEASED (Type or print) Edith F. Culbert		4. DATE OF DEATH Month 10 Day 20 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-16
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM H. LARGE		14. MOTHER'S MAIDEN NAME MARY MAUPIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 077-05-8565	
17. INFORMANT Bernice Santos		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO (b) Carcinoma of breast DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 10-21-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 23, 1967	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM		23d. LOCATION (City or town) (County) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co RIVERDALE, MD		25a. REC'D BY REGISTRAR DATE NOV 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

MEDICAL CERTIFICATION

1055

1055

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14272

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14276

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 7614 Romney Court	
3. NAME OF DECEASED (Type or print) Irene Mae Cummings		4. DATE OF DEATH Month 10 Day 14 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Dec., 1906
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Jackson		14. MOTHER'S MAIDEN NAME Mary Halderman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Leroy E Cummings		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus-over 15 yrs.			INTERVAL BETWEEN ONSET AND DEATH Minutes Unknown
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		22. DATE SIGNED 10-14-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY United Cemetery		23d. LOCATION (City or Town) (County) (State) Pittsburg Pa	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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John R. [illegible]

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14273

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14277

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Elmer Darby		4. DATE OF DEATH Month 10 Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Oct. 1924
9. AGE (In years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction laborer		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) West Va		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME Spence Darby		14. MOTHER'S MAIDEN NAME Myrtle L Odell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Erma Darby		Address 4000 36st Mt Rainier, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 802 X IMMEDIATE CAUSE (a) Laceration of brain DUE TO Trauma - struck by train. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 11 days			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by train	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:00pm p.m. 9-24-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St., Hyattsville, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-5-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR OCT 9 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film G398 3/12/68 KK

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14274

14278

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN Tb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrew's Air Force Base Hospital		d. STREET ADDRESS 504 Maple Road	
3. NAME OF DECEASED (Type or print) Swannie Annie First Middle Last M Darne		4. DATE OF DEATH Month 10 Day 24 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 May 1911
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Dawson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Doris Tedrow Same As # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebro vascular hemorrhage DUE TO Hypertensive vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-25-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/67	
23c. NAME OF CEMETERY OR CREMATORY Great Falls Cemetery Herndon, Virginia		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Robert E. Wilhelm		25a. REC'D BY REGISTRAR OCT 30 1967	
Address 4308 Suitland Road, Suitland, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
25M 1/67

Item 18 Film 395 11-20-MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14275					14279				
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital, Glenn Dale, Md.					d. STREET ADDRESS 3220 Conn. Ave., N. W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth D. Darr					4. DATE OF DEATH Month Day Year 10 29 1967				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6/28/1908		9. AGE (In years last birthday) yrs. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer			10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry F. Dill					14. MOTHER'S MAIDEN NAME Elizabeth Schrone				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 579-14-0874		17. INFORMANT Decedent Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumococcal meningitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Pneumococcal pneumonia, left upper lobe								INTERVAL BETWEEN ONSET AND DEATH 8 days 17 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no other conditions								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that he (this hospital) attended the deceased from 10/19/ , 19 67 , to 10/29/ , 19 67 , that he (we) lost saw the deceased alive on 10/29/ 1967, and that death occurred at 11:30A M, from causes on and on the date stated above.									
22a. SIGNATURE <i>Moe Weiss</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/29/67		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.					22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/29/67		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>Forley + baronough</i>					25a. REC'D BY REGISTRAR DATE NOV 3 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

Part II Chronic Alcoholism - Deleted
11/20/67

Prince George

Glenn Dale (retail) 10 days

Glenn Dale Hospital, Glenn Dale, Md. 1220 Conn. Ave., N. W.

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Glenn Dale Hospital 10 days

Glenn Dale Hospital 10 days

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Glenn Dale Hospital 10 days

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14278											
14280											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forest Hghts			c. LENGTH OF STAY IN 1b 20 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forest Heights 16-1						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 11--Delaware Dr., S. E.					d. STREET ADDRESS 11--Delaware Dr., SE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle G. Last DISNEY		4. DATE OF DEATH Oct. 8th 1967		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH June 23-1897		9. AGE (in years last birthday) 70 yrs.		10. AGE (in years last birthday) 70 yrs.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Laundry Work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME George Price					14. MOTHER'S MAIEN NAME Almira Turnhaugh						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 579 05 6516		17. INFORMANT Wm. C. Disney Jr.		Address Same as Item #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Congestive Heart Failure (b) Rheumatic fever / Mitral Stenosis (c) DUE TO DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 30 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIOENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4. 24, 1962, to 10. 3, 1967, that (I) (we) last saw the deceased alive on 10. 3. 1967 19, and that death occurred at 6A M, from the causes and on the date stated above.											
22a. SIGNATURE Dr. Etienne Szollosi					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.O. 22b. DATE SIGNED Oct. 8-1967						
22c. PHYSICIAN'S NAME (Type) Dr. Etienne Szollosi					22d. ADDRESS #2 Parkway Dr., SE Forest Hghts, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 11-67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Bladensburg, Md.					
24. FUNERAL DIRECTOR Simmons Bros.					ADDRESS 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR OCT 11 1967				
							25b. REGISTRAR'S SIGNATURE Charles J. [Signature]				

14300

CERTIFICATE OF DEATH

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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14278

14281

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 10 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Mannor, 4922 LaSalle Road				d. STREET ADDRESS 508 Crittenden St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosina Irene DUGAN				4. DATE OF DEATH Month Day Year Oct 13 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 15, 1876	
9. AGE (In years lost birthday) yrs. 91		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Caffrey				14. MOTHER'S MAIDEN NAME Jenny O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Sister M. Dominic - Carroll Mannor			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4501 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) gangrene Right leg (c) generalized arterio sclerosis and Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 72 hours 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to 1967, that (I) (we) last saw the deceased alive on 10/12/67 19, and that death occurred at 12:15 PM from the causes and on the date stated above.							
22a. SIGNATURE William F. Simpson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/13/67	
22c. PHYSICIAN'S NAME (Type) WILLIAM F. SIMPSON				22d. ADDRESS 6216 NH Ave NE - Wash. DC.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons, Washington, D.C. 20016				25a. REC'D BY REGISTRAR OCT 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10301

CERTIFICATE OF DEATH

10301

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF WITNESSES: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

[illegible handwritten notes and signatures]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14278

14283

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 15 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospigial				d. STREET ADDRESS 327 Montgomery St.	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas W. Elliott				4. DATE OF DEATH Month Day Year Oct. 18, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/95		9. AGE (In years birth day) yrs. 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Thomas Elliott			14. MOTHER'S MAIDEN NAME Margaret Ritter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 4308 Sandy Spring Rd. Charlotte E. Stoner, Burtonsville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Myocardial O.V. Disease DUE TO (c) Chronic Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/3/67 , 19 to 10/18/67 , that (I) (we) last saw the deceased alive on 10/17/67 , and that death occurred at 6:45 PM , from causes and on the date stated above.					
22a. SIGNATURE Paul H. Whitten		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/18/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Oct 23, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Hall Cemetery	23d. LOCATION (City or town) (County) (State) Arlington, Va	24. FUNERAL DIRECTOR Walter Waters	
25a. REC'D BY REGISTRAR 1		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14279

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14284

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 4409 38th. Street			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Elmer Embrey				4. DATE OF DEATH Month Day Year 10 4 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Jan. 1904		9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Sgt. U.S. Pentagon Bldg		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MARSHALL EMBREY				14. MOTHER'S MAIDEN NAME MARY GARRETT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 1922-1925		16. SOCIAL SECURITY NO. 578149534		17. INFORMANT ELSIE MAY EMBREY, Same AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH minutes over 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 5 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				22. DATE SIGNED 10-5-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF OCT. 7, 1967		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS, Co. RIVERDALE, MD				25a. REC'D BY REGISTRAR DATE OCT 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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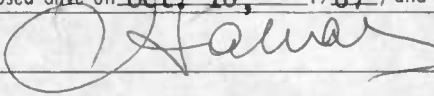
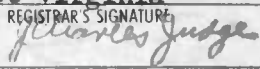
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
14285										
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 4818 Eastern Lane					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Virginia S. Falls					4. DATE OF DEATH Month Oct. Day 10, Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/15/XX 96		9. AGE (In years lost birthday) yrs. 71		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Scott					14. MOTHER'S MAIDEN NAME Velaria O. Lawson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Velaria S. Kittredge, Same As # 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 180X IMMEDIATE CAUSE (a) Renal Cell Carcinoma of left kidney (Hypernephroma) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) Essential Hypertension								INTERVAL BETWEEN ONSET AND DEATH 2 years 3 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) this hospital attended the deceased from May , 19 67 , to Oct. 10, 19 67 , that (I) we saw the deceased alive on Oct. 10, 19 67 , and that death occurred at 7:50P M, from causes and on the date stated above.										
22a. SIGNATURE  M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 10, 1967			
22c. PHYSICIAN'S NAME (Type) Ohannes Sahakyan, M.D.					22d. ADDRESS 6001 Landover Rd. Cheverly, Md. 20785					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/15/67		23c. NAME OF CEMETERY OR CREMATORY Greenbriar Cemetery			23d. LOCATION (City or Town) (County) (State) Hinton West Virginia			
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home Wilhel 4308 Suitland Rd, Suitland, Md.					25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE 			

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number 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840,

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Verdine, J. L., & Johnson, J. A. (1996).

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CERTIFICATE OF DEATH

14286

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Pr Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u>		c. LENGTH OF STAY IN 1b <u>101 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LELAND Memorial Hospital</u>		d. STREET ADDRESS <u>4907 Franklin Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>HAZEL</u> Middle <u>E</u> Last <u>FARRELL</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-94</u>
9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR Months <u>23</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>WASH DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J Snider</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE COCKERILL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>577-01-2650</u>	
17. INFORMANT <u>Hosp Records</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Chl Pericarditis & Myocardial Infarction</u> DUE TO (b) <u>Hypertensive Cerebral Vascular Dis & Hemiparesis</u> DUE TO (c) <u>Adv Hemiparesis/Embolism</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/10</u> , 19 <u>67</u> , to <u>Oct 29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/28</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>W.L. Etienne</u>		22b. DATE SIGNED <u>10/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>		22d. ADDRESS <u>College Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland 'ro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>Nov 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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WRETE COOPER

4-29, 9-20

Handwritten signature: *Wm. L. G. ...*

[Signature]

7/11

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10/10/01
M. M. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14282 CERTIFICATE OF DEATH 14287											
1. PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham				c. LENGTH OF STAY IN lb 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Magnolia Gardens Nursing Home						d. STREET ADDRESS 1325 - Nicholson St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Irene E. Finley						4. DATE OF DEATH Month Oct. Day 18 Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/1890		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Stenographer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) New Jersey			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Maher						14. MOTHER'S MAIDEN NAME Teresa Tulley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 150-34-6479-A		17. INFORMANT Chas. T. Finley (above address) (Son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>1810</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cancer of bladder</i> DUE TO (c) <i>4 months</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>pericardial aneurysm</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1965, 19 67 that (I) (we) last saw the deceased alive on Oct 18 1967, and that death occurred at 855 A Oct 18 M, from causes and on the date stated above.											
22a. SIGNATURE <i>Samuel H. M.D.</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct 18, 1967			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.			23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.				
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE OCT 23 1967		25b. REGISTRAR'S SIGNATURE <i>W. Charles Judge</i>			

1-1539

RECORDS OF DEATH

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CERTIFICATE OF DEATH

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14288

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 27 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 600 Addison Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carl M. Fischer		4. DATE OF DEATH Month Oct. Day 20 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/08
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 16 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl M. Fisher		14. MOTHER'S MAIDEN NAME Catherine Preston	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Frances M. Fischer, wife		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma, left upper lobe DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from July 1, 1967 to Oct. 20, 1967 , that (I) was lost saw the deceased alive on Oct. 20, 1967 , and that death occurred at 8:30AM , from causes and on the date stated above.			
22a. SIGNATURE William Brainin M.D.		22b. DATE SIGNED Oct. 20, 1967	
22c. PHYSICIAN'S NAME (Type) William Brainin, M. D.		22d. ADDRESS 6124 Central Ave. Capital Hghts. Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/24/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Princes Georges, Maryland
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25. REC'D BY REGISTRAR OCT 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11283

REPORT OF DEATH

11283

Name of Deceased		Date of Death		Place of Death	
Carl E. Fisher		Oct. 20, 1961		Washington, D.C.	
Sex		Age		Marital Status	
Male		37		Married	
Race		Occupation		Cause of Death	
White		Physician		Heart disease	
Birth Date		Birth Place		Date of Burial	
Oct. 20, 1924		Washington, D.C.		Oct. 20, 1961	
Burial Place		Funeral Home		Signature of Physician	
Arlington National Cemetery		Fisher & Sons		[Signature]	
Name of Informant		Relationship		Signature of Informant	
Frances E. Fisher, wife		Wife		[Signature]	
Name of Attending Physician		Signature of Attending Physician		Date of Report	
Dr. [Name]		[Signature]		Oct. 20, 1961	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14284

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14289

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2709 Nicholson Street		d. STREET ADDRESS 2709 Nicholson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose Lillian Fleishman		4. DATE OF DEATH Month 10 Day 2 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1917
9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-typist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Fleishman		14. MOTHER'S MAIDEN NAME Frieda Finn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT Brother		Address S.S. Jacob Fleishman 9713 Saxony Rd. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of myocardium DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) From coronary occlusion left coronary artery DUE TO From coronary atherosclerotic heart disease (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 10-3-67	
23a. BURIAL, CREMATION, RITUAL, etc. Burial		23b. DATE THEREOF 10-4-67	
23c. NAME OF CEMETERY OR CREMATORY Ohev Sholom-Talmud Torah Cem. Washington DC		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Bernard Danzansky and Sons Washington, DC		25a. REC'D BY REGISTRAR OCT 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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1998

• 2 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14285 CERTIFICATE OF DEATH 14290											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 4512 Rhode Island Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ernest Foster						4. DATE OF DEATH Month Day Year Oct. 8, 19 67					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/04		9. AGE (In years lost birthday) yrs. 63		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Foster						14. MOTHER'S MAIDEN NAME Sosie Johnson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Blanche Newman 4404 Brooks PL NE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal aneurysm 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) Sclerosis										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Tuberculosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Sept. 26, 19 67 , to Oct. 8, 19 67 , that (X) (we) last saw the deceased alive on Oct. 8, 19 67 , and that death occurred at 3:15 PM , from causes and on the date stated above.											
22a. SIGNATURE Fidel J. Quintana						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Fidel J. Quintana, M. D.						22d. ADDRESS Prince Georges General Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10-14-67		23c. NAME OF CEMETERY OR CREMATORY Harmony				23d. LOCATION (City or Town) (County) (State) Highland Park Md			
24. FUNERAL DIRECTOR H.S. Washington						ADDRESS 4905 Deane Ave		25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

2822

1994-1995

Chapter 12

Prince Georges General Hospital

Figure 2

130

1961-1962

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14286

14291

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harvey		4. DATE OF DEATH Month 10 Day 23 Year 19 67	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-1881
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aarron Fox		14. MOTHER'S MAIDEN NAME Rebecca Fox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217 30 0266	
17. INFORMANT Carrie F. Hill		Address 624 Hamilton St.N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Heart Failure DUE TO (b) Arteriosclerotic Heart Disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			22. DATE SIGNED 10-23-67
ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland		23. LOCATION (City or Town) (County) (State) Oxon Hill, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 10/27/67		23b. DATE THEREOF 10/27/67	
23c. NAME OF CEMETERY OR CREMATORY St. Paul Methodist		23d. LOCATION (City or Town) (County) (State) Oxon Hill, Md.	
24. FUNERAL DIRECTOR ROBERT B. MASON FUNERAL HOME, INC. 2500 NICHOLS AVENUE, S. E.		25a. REC'D BY REGISTRAR OCT 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1934

1934

1934

1
FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME13
6M 1/67

14287

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14292

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 50 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jennifer Lynn Fyfe		4. DATE OF DEATH Month 10 Day 26 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1966
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 6 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Raymond Fyfe		14. MOTHER'S MAIDEN NAME Gloria Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) --		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Raymond Fyfe		Address Landover, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3400 IMMEDIATE CAUSE (a) Meningitis (hemophilus influenza) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-26-67	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 10-26-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF Oct 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.	
25a. RECEIVED BY REGISTRAR OCT 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1951

1951

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and limitations of the experiment.

3. The third part of the report is a discussion of the results. It compares the results with the theoretical predictions and with the results of other experiments. It also discusses the implications of the results and the conclusions drawn from them.

4. The fourth part of the report is a summary of the work. It briefly reviews the main points of the report and states the conclusions.

Submitted by: [Name]

1951

1951

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14288

14293

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN TB 6 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 407 Montrose Avenue		d. STREET ADDRESS 407 Montrose Avenue	
3. NAME OF DECEASED (Type or print) Claire V Galloway		4. DATE OF DEATH Month 10 Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 March 1925
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Advertising	
11. BIRTHPLACE (State or foreign country) Rosedale, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Virgil Galloway		14. MOTHER'S MAIDEN NAME Margurite Olive Jewell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW 11		16. SOCIAL SECURITY NO. WW 11	
17. INFORMANT Margurite Hill, 791 Forest St., Denver, Colo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-17-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Oct 19 1967	23c. NAME OF CEMETERY OR CREMATORY St. John's	23d. LOCATION (City or town) (County) (State) Columbia Manor P.G. Md
24. FUNERAL DIRECTOR Robert R. Riddick		ADDRESS Laurel, Md.	
25a. REC'D BY REGISTRAR OCT 25 1967		25b. REGISTRAR'S SIGNATURE John Kehoe, M.D.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14282

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14294

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>		c. LENGTH OF STAY IN lb <u>3 yrs. 3 mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>		d. STREET ADDRESS <u>7318 Powhatan St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDENS NURSE HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARA M GANT</u>		4. DATE OF DEATH Month Day Year <u>October 7 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 Jan 1879</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>88</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Tobias Nolan</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Day</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-58-8022</u>	
17. INFORMANT <u>Mr. Robt. Keller</u>		Address <u>St. Leo Barber Rd. Davidsonville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PNEUMONIA</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>24 hrs.</u> <u>10 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>63</u> , to <u>Oct</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 6</u> , 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Thomas G. Maloney</u> M.D.		22b. DATE SIGNED <u>Oct 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas G. Maloney</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 11 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Indianapolis Ind</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers Co.</u>		25a. REC'D BY REGISTRAR <u>Oct 11 1967</u>	
ADDRESS <u>Riverdale, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14290

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14295

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph Paul Gelardo		4. DATE OF DEATH Month 10 Day 5 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-17-1918
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 10 Days 5 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Anthony Macellaro		14. MOTHER'S MAIDEN NAME Camille Macellaro	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) W W 11		16. SOCIAL SECURITY NO. 088 16 8991	
17. INFORMANT Camille F Gelardo		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) over 2 yrs.			INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-6-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR F Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 9 1967	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS 301 W. PPESTON STREET, BALTIMORE, MARYLAND 21201											
Item #9 Film #G394 10/27/67 ph											
Item #2 Film #G394 11/6/67 ph											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY, G.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE				c. LENGTH OF STAY IN lb 32 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENINGTON // Lewisdale 16.1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E. LELAND MEMORIAL						d. STREET ADDRESS 2302 Drexel St. KENINGTON // NSNG. HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHERINE First Middle Last W. GILL						4. DATE OF DEATH Month 10 Day 14 Year 19 67					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH- 12-27-86		9. AGE (In years, months, and days) 36/8/86		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) TEXAS				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES GILL						14. MOTHER'S MAIDEN NAME MC CORMICK					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKN				16. SOCIAL SECURITY NO. 579 44 9185		17. INFORMANT HOSPITAL RECORDS Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO (b) Hypertensive Heart disease (c) Uremia + circulatory fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 1B.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 10-11, 1967, to 10-14, 1967, that (I) (we) last saw the deceased alive on 10-14 1967, and that death occurred at 11:30 PM, from causes on and on the date stated above 22a. SIGNATURE R.F. Wilkinson M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) R.F. Wilkinson 22d. ADDRESS 4400 Queensbury Rd. Riverdale, Maryland 22b. DATE SIGNED 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 10-18-67		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY			23d. LOCATION (City or Town) (County) (State) WASHINGTON D. C.			
24. FUNERAL DIRECTOR GASCH'S						25a. REC'D BY REGISTRAR HYATTSVILLE, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge			

1931

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U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

TO THE DIRECTOR
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

FROM THE DIRECTOR
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

SUBJECT: [Illegible]

[Illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital						d. STREET ADDRESS Hamilton Hotel University Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theo			First			Middle Claire			Last Glenn		
4. DATE OF DEATH 10/9/1967		Month		Day		Year					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/11/90		9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Secretary - Wm. Green, AFL				10b. KIND OF BUSINESS OR INDUSTRY Ohio				11. BIRTHPLACE (County & State, or foreign country) Ohio			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME James Glenn				14. MOTHER'S MAIDEN NAME Emma Lawyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 579-01-2486				17. INFORMANT decendent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonitis 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Generalized arteriosclerosis (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 48 hrs. unknown unknown											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (q) Old cerebrovascular accident; old anterior myocardial infarction, extensive, healed; hiatal hernia, large; cholelithiasis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/11/1967 to 10/9/1967 , that XX (we) lost saw the deceased alive on 10/9/67 , and that death occurred on 10/9/67 at 2:30PM , from causes on and on the date stated above.											
22a. SIGNATURE Moe Weiss						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10/9/67		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.						22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL Removal		23b. DATE THEREOF 10/12/67		23c. NAME OF CEMETERY OR CREMATORY Southlawn				23d. LOCATION (City or Town) (County) (State) Coshocton, Ohio			
24. FUNERAL DIRECTOR SH HINES Co. 2901 14th St. N.W. DC						25a. REC'D BY REGISTRAR DATE OCT 13 1967		25b. REGISTRAR'S SIGNATURE f Charles Judge			

12345

James George

Glenn Dale (oral)

2 months

Washington, D.C.

Glenn Dale Hospital

2 University Hospital

Thos

Glenn

Glenn

17

6/1/30

17

Glenn Dale Hospital

Ohio

USA

James Glenn

Born January

2/29-01-1888

deceased

no

Glenn Dale Hospital

Glenn Dale Hospital

Glenn Dale Hospital

Glenn Dale Hospital, Glenn Dale, Md.

no

no

no

Glenn Dale Hospital, Glenn Dale, Md.

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Glenn Dale Hospital, Glenn Dale, Md.

Glenn Dale Hospital, Glenn Dale, Md.

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Glenn Dale Hospital, Glenn Dale, Md.

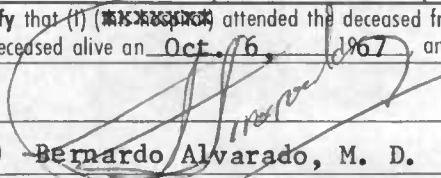
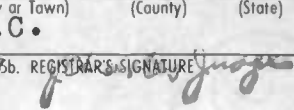
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14298											
CERTIFICATE OF DEATH											
14298											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale d. STREET ADDRESS 6823 Riverdale Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Glodeck						4. DATE OF DEATH Month Day Year Oct. 6, 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1967		9. AGE (In years last birthday) yrs. 4		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John W. Glodeck						14. MOTHER'S MAIDEN NAME Joann B. Remeta					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mr. John W. Glodeck (above address)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 Intracranial hemorrhage, ventricular; cause undetermined. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (we) attended the deceased from Oct. 2, 1967 , to Oct. 6, 1967 , that (I) (we) saw the deceased alive on Oct. 6, 1967 , and that death occurred at 1:35 AM from causes and on the date stated above.											
22a. SIGNATURE 						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. AM DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.						22d. ADDRESS 6201 Riverdale Rod. Riverdale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION (City or Town) (County) (State) Wash., D.C.			
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.						ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR Oct 9 1967		25b. REGISTRAR'S SIGNATURE 	

VR A15 (4)
25M 1/67

7-279514

1-1304

THE HOUSE OF COMMONS

1908

Prince George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

George's Hospital

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14294

14299

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville c. LENGTH OF STAY IN Tb 16-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
3. NAME OF DECEASED (Type or print) Wilma Olean Goforth		4. DATE OF DEATH Month 10 Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-1935
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 10 Days 29 Hours 19 Min. 67	
11. BIRTHPLACE (State or foreign country) OKLAHOMA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HENRY GOFORTH		14. MOTHER'S MAIDEN NAME LOUELLA FULLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1958-1964		16. SOCIAL SECURITY NO. 443-32-6698	
17. INFORMANT MRS LUELLA GOFORTH		OKLAHOMA CITY, OKLAHOMA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Shot self in head with .22 cal. rifle.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) Shot self in head with .22 cal. rifle.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:00pm p.m. 10-29-1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) same as #2
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-30-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 3, 1967	23c. NAME OF CEMETERY OR CREMATORY SUNNY LANE CEM	23d. LOCATION (City or Town) (County) (State) OKLAHOMA CITY, OKLAHOMA
24. FUNERAL DIRECTOR W.W. CHAMBERS Co.		25a. REC'D BY REGISTRAR NOV 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11507

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14295

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14300

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 10M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. LENGTH OF STAY IN 1b West Hyattsville 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2709 Kirkwood Place		d. STREET ADDRESS 2709 Kirkwood Place	
3. NAME OF DECEASED (Type or print) Milton P Gosnell		4. DATE OF DEATH Month 10 Day 2 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 April 1893 74 yrs.
9. AGE (In years lost birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book6 Binder Publishing Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gosnell		14. MOTHER'S MAIDEN NAME Mary Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 666		16. SOCIAL SECURITY NO. 579-03-740	
17. INFORMANT Harriet B. Gosnell		Address same@ #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Carcinoma of rectum 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH over 1 yr. over 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-3-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G's. Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR OCT 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14296						14301					
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>				c. LENGTH OF STAY IN 1b <u>10 MOS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT. #3 CHESTERTOWN</u>				142	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDENS NURS. HOME</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>H. GRABENSTEIN</u> Last						4. DATE OF DEATH Month <u>OCT.</u> Day <u>16</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>CAU.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/7/1905</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>CUMBERLAND MO.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Clifford Elliott</u>						14. MOTHER'S MAIDEN NAME <u>Mary Lynch</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Anthony Grabenstein, 2 Brooke Ave. Annapolis Md</u>				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>Oct 16</u> , 19 <u>67</u> , that (I) <u>was</u> saw the deceased alive on <u>Oct 16</u> , 19 <u>67</u> , and that death occurred at <u>1215</u> M, from causes on and on the date stated above.											
22a. SIGNATURE <u>Leon R Hevitsky</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/16/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leon R Hevitsky</u>						22d. ADDRESS <u>Mt. Rainier Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
<u>Burial</u>		<u>10/19/1967</u>		<u>Sts. Peter & Paul's Cath Cem</u>		<u>Cumberland Alleg Md</u>					
24. FUNERAL DIRECTOR <u>John J. Hafer, Jr.</u>						25a. REC'D BY REGISTRAR <u>Oct 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1-1901

STATE OF NEW YORK

1893

IN SENATE,
January 15, 1901.
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 15, 1893.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1893.

NEW YORK
JAN 15 1901
RECEIVED
MT. KENNEDY
JAN 15 1901

14297

CERTIFICATE OF DEATH

F. 14302

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS West Phila Rd.	
3. NAME OF DECEASED (Type or print) Samuel A Gray		4. DATE OF DEATH Oct., 26 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Dec., 1904
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Gray		14. MOTHER'S MAIDEN NAME Julia Bowen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-16-0125	
17. INFORMANT Mrs. Geraldine Gray		Address 1400 Westphalia Forestville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis (infarction) DUE TO (b) Cerebral thrombosis Pneumonia DUE TO (c) Generalized atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that Dr. (this hospital) attended the deceased from Oct. 15, 1967 , to Oct. 26, 1967 , that (x) (we) last saw the deceased alive on Oct. 26, 1967 , and that death occurred 8:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Fidel J. Quintana		22b. DATE SIGNED Oct. 26, 1967	
22c. PHYSICIAN'S NAME (Type) Fidel J. Quintana, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-31-67	23c. NAME OF CEMETERY OR CREMATORY Harmony Park	23d. LOCATION (City or Town) (County) (State) Lindover Md
24. FUNERAL DIRECTOR Kellum 4339-Aust PL-NE		25a. REC'D BY REGISTRAR OCT 30 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14298

Items #9, 11, 12, 13 & 14 Film #G394 11/6/67 ph

14303

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS Post Office Box #121	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daniel Mathew Griffin		4. DATE OF DEATH Month 10 Day 13 Year 1967	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-01
9. AGE (In years last birthday) 65 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Daniel Griffin		14. MOTHER'S MAIDEN NAME Susie Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH over 2 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus for over nine years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-14-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10-16-67	23c. NAME OF CEMETERY OR CREMATORY Harmony	23d. LOCATION (City or town) (County) (State) Landover, Md
24. FUNERAL DIRECTOR Frogia 389 B.I. cu nw w...		25. REC'D BY REGISTRAR OCT 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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14298

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14304

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		d. STREET ADDRESS <u>514 Independence Ave.,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Clinton Meecal Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Karla Joe Gudenberg</u>		4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 Feb., 1963</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Karl Gudenberg</u>		14. MOTHER'S MAIDEN NAME <u>Anita Chidichimo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Karl Gudenberg father same as 2D</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of beain</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>8164</u> (c) <u>8164</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger, thrown from car in collision.</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:20 PM. 8 14 19 67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St. Rt. 5</u>		20f. (City or town) <u>Clinton</u> (County) <u>P.G.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u>		22. DATE SIGNED <u>10-15-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, M.D., Riverdale</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>10/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 17 1967</u>	

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UNITED STATES DEPARTMENT OF THE ARMY

FOR THE

OFFICE OF THE ADJUTANT GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14300		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14305	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights</u>		c. LENGTH OF STAY IN 1b <u>5 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights</u> <u>16-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8720 - 62 Ave</u>		d. STREET ADDRESS <u>8720 - 62nd Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALICE L</u> First Middle Last <u>HADLEY</u>		4. DATE OF DEATH <u>Oct</u> Month <u>9</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>MAY 15, 1877</u>		9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>James Smith</u>		14. MOTHER'S MAIDEN NAME <u>Margaret S. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-46-6016</u>		17. INFORMANT <u>MRS ALICE FLAHERTY (daughter)</u> Address <u>SAVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> DUE TO <u>BILATERAL PULMONARY EDEMA secondary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>to Acute Congestive Heart Failure</u> (c) <u>ARTERIO/SCLEROTIC CARDIO VASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 MIN</u>		5YR +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> 19 <u>Oct</u> to <u>Oct</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 9</u> 19 <u>67</u> , and that death occurred at <u>4:45</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>WL Etienne</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/9/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>WL. ETIENNE, M.D.</u>		22d. ADDRESS <u>COLLEGE PARK MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairfax Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Fairfax, Virginia</u>					
24. FUNERAL DIRECTOR <u>Everly Funeral Home</u> ADDRESS <u>By <u>Onuma</u> Mgr. Fairfax, Va.</u>		25a. REC'D BY REGISTRAR <u>OCT 16 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

14301

14306

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 1109 57th. Avenue	
3. NAME OF DECEASED (Type or print) William Hallman		4. DATE OF DEATH Month 10 Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 25 Sept. 1895
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Elevator Engr.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Phil. Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Washington Hallman		14. MOTHER'S MAIDEN NAME Catherine McGinley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI 12-9-17 1-31-19		16. SOCIAL SECURITY NO. 12-9-17 1-31-19	
17. INFORMANT Wife Address Margaret J. Hallman Same as Item #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 10-2-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 6-1967	23c. NAME OF CEMETERY OR CREMATORY Fern Wood Cemetery	23d. LOCATION (City or Town) (County) (State) Fern Wood, Pa.
24. FUNERAL DIRECTOR Simmons Bros.		25a. REC'D BY REGISTRAR OCT 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Town PM3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14302

14307

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 8205 Milligan Lane	
3. NAME OF DECEASED (Type or print) David Spencer		4. DATE OF DEATH Month 10 Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 June 1943
9. AGE (In years lost birthday) 24 yrs.		IF UNDER 1 Year Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William A Hamm	
14. MOTHER'S MAIDEN NAME Betty Sue Manuel		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO.		17. INFORMANT William A. Hamm Address Same As 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 8234 IMMEDIATE CAUSE (a) Bilateral hemothorax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of spleen and left kidney DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran off road and hit a guard rail	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:30am 10-8- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wash. Beltway, north of Rt. 202		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kenoe		22. DATE SIGNED 10-9-67	
EXAMINER'S NAME (Type) John Kenoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm		25a. REC'D BY REGISTRAR OCT 11 1967	
Address 4308 Suitland Road, Suitland, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

1-1307

1-1307

John G. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14303											
Item #1b & d Film #G394 11/6/67											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE Co.						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGE					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pr. Geo. General Hosp.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First HOMER H. Middle HANBACK Last HANBACK						4. DATE OF DEATH Month 10 Day 23 Year 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5-11-1885		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 23 Hours 16 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION				11. BIRTHPLACE (County & State, or foreign country) WARRENTON, VA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN W. HANBACK						14. MOTHER'S MAIDEN NAME ANNA LEE BALL					
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-09-1397		17. INFORMANT MABEL M. AMISS 7404 OXENHILL RD Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5371 Congestive Heart Failure Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure Chronic (c) Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day Months YEARS											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/22, 1962 , to 10/23, 1962 , that (I) (we) last saw the deceased alive on 10/19, 1962 , and that death occurred at 10/23, 1962 , from the causes and on the date stated above.											
22a. SIGNATURE Thomas Larkin Fieldson						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10/23/67		
22c. PHYSICIAN'S NAME (Type) THOMAS LARKIN FIELDSON						22d. ADDRESS BRANDYWINE, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10-25-67		23c. NAME OF CEMETERY OR CREMATORY BEALTON CEMETERY		23d. LOCATION (City, town or county) (State) BEALTON VA.			
24. FUNERAL DIRECTOR J. W. Lee & Sons						25a. REC'D BY REGISTRAR OCT 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14304

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G393 10/13/67 ph

CERTIFICATE OF DEATH

14309

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN lb <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		1611	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CLINTON Community Hospital</u>				d. STREET ADDRESS <u>10604 Ridge Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELCANY C. HARLESS</u>				4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-88</u>	9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>IRON WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MATTHEWS, WEST VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MOSES HARLESS</u>				14. MOTHER'S MAIDEN NAME <u>MARY MOYER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>PAUL HARLESS</u> Address <u>253 NO. ST. JOHN'S LANE ELLICOTT CITY, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 ATRIAL FIBRILLATION</u> DUE TO (b) <u>A.S.H.D.</u> DUE TO (c) <u>Coronary Heart Failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>UNK.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u>Extreme old age. Hydrothorax</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>9/30</u> , 19 <u>67</u> , to <u>10/3</u> , <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/3</u> , <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert Merkle</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT MERKLE</u>				22d. ADDRESS <u>116 HENDERICK ROAD BRANDYWINE, MD</u>			
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATL.</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND. MD.</u>			
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO. INC. WASH. D.C.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>517 N. ST. SE</u>				DATE <u>OCT 6 1967</u>			

1300

PLATE NO. 1300

1300

ATLAS OF THE

A. S. W. D.

14305

CERTIFICATE OF DEATH

14310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		Leland Memorial Hospital MARYLAND c. LENGTH OF STAY IN lb 7 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 9514 Rhode Island Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First M Middle Elinor Last Harr		4. DATE OF DEATH Month October Day 25 Year 1967			
5. SEX Female	a. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/88	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Scaggs, Pinkney		14. MOTHER'S MAIDEN NAME Larrick, Cora		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 577-24-2950D		17. INFORMANT Address College Park Scaggs, Lucy, 9514 Rhode Is. Av.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic Cardiovascular disease DUE TO Palatal Bronchopneumonia DUE TO Toxic renal failure secondary to #1 above CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Oct 18, 1967 to Oct 25, 1967 , that (I) (we) last saw the deceased alive on Oct 25, 1967 , and that death occurred at 11 A.M. from causes and on the date stated above.					
22a. SIGNATURE W. L. Etienne		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/25/67	
22c. PHYSICIAN'S NAME (Type) W. L. ETIENNE		22d. ADDRESS College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 28, 1967		23c. NAME OF CEMETERY OR CREMATORY St John's Cemetery	
23d. LOCATION (City or Town) (County) (State) Beltsville Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR OCT 30 1967	
25b. REGISTRAR'S SIGNATURE [Signature]					

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0160-2908/95/0005-0000\$05.00/0

To the Hon. Secy of the
 Interior, Washington
 D.C.

Alfred Smith

10/2/20

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10/20/10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 396

12-22-67 am

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 19 min.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville-Kentland, Md.		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 2974 Markham Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anna Louise Hester		4. DATE OF DEATH Month 10 Day 8 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Feb. 1925
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? Ohio	
13. FATHER'S NAME Russella A. Brown sr		14. MOTHER'S MAIDEN NAME Mabel M Pressel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Edward J Hester		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Aspiration of gastric contents (b) Etiology undetermined DUE TO Etiology undetermined (c) Etiology undetermined		INTERVAL BETWEEN ONSET AND DEATH 795.5	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.O.		22. DATE SIGNED 10-9-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Donnellsville Clark co Ohio	
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge	

11311

8053

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and uncertainties involved in the measurements.

3. The third part of the report is a discussion of the results. It compares the experimental results with the theoretical predictions and discusses the implications of the findings. It also mentions the limitations of the study and suggests directions for future work.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and states the overall conclusions. It also mentions the significance of the results and the contribution of the study to the field.

[Handwritten signature]

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and uncertainties involved in the measurements.

3. The third part of the report is a discussion of the results. It compares the experimental results with the theoretical predictions and discusses the implications of the findings. It also mentions the limitations of the study and suggests directions for future work.

4. The fourth part of the report is a conclusion. It summarizes the main findings of the study and states the overall conclusions. It also mentions the significance of the results and the contribution of the study to the field.

CERTIFICATE OF DEATH

14312

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel General Hospital		d. STREET ADDRESS 803 Faulkner Ave	
3. NAME OF DECEASED (Type or print) Irene Leola Hicks		4. DATE OF DEATH Oct 9 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11 1894 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Counselor U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Howard Co. Md	
13. FATHER'S NAME Daniel A. Reister		14. MOTHER'S MAIDEN NAME Mary Elizabeth Fulton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Margaret Nicholson		Address 203 Whiteaway Laurel Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) 48 hours			INTERVAL BETWEEN ONSET AND DEATH 48 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7 OCT , 19 67 , to 9 OCT , 19 67 , that (I) (we) last saw the deceased alive on 8 OCT , 19 67 , and that death occurred at 5A M, from causes and on the date stated above.			
22a. SIGNATURE Richard Compton		22b. DATES SIGNED 11 OCT 67	
22c. PHYSICIAN'S NAME (Type) J. Richard Compton, M. D.		22d. ADDRESS 612 Main Street, Laurel, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-11-67	23c. NAME OF CEMETERY OR CREMATORY Trinity Hill Cem	23d. LOCATION (City or Town) (County) (State) Laurel Md
24. FUNERAL DIRECTOR De Witt Canfield		25a. REC'D BY REGISTRAR DATE OCT 17 1967	
		25b. REGISTRAR'S SIGNATURE James Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11315

RECORD OF DEATH

11361

PRINCE GEORGE

11315

11361

11315

11361

11315

11361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
14308														
14313														
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlborough 16 yrs.					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlborough									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chelsea Farm, Box 2338					d. STREET ADDRESS Chelsea Farm, Box 2338									
3. NAME OF DECEASED (Type or print) First Leen Middle --- Last Hnativ					4. DATE OF DEATH Month October Day 20 Year 1967									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 10, 1908		9. AGE (In years last birthday) 59 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Tenant		11. BIRTHPLACE (County & State, or foreign country) Ukrania		12. CITIZEN OF WHAT COUNTRY? Ukrania								
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. -----					17. INFORMANT Address Anna Hnativ- Same as Item #2.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Carcinoma of lung Conditions, if any, which gave rise to immediate cause (b) DUE TO Carcinoma of lung (c) stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 1 mos 4 mos										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from May 1967 to Oct 20, 1967 , that (I) (we) last saw the deceased alive on 20 Oct 1967 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Dr. Robert B. Sasscer, M.D.					22b. DATE 10/20/67									
22c. PHYSICIAN'S NAME (Type) Dr. Robert B. Sasscer, M.D.					22d. ADDRESS Upper Marlborough, Md. 20870									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/67		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem:		23d. LOCATION (City, town or county) (State) Suitland Maryland								
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro, Md.					25. RECORD BY REGISTRAR OCT 30 1967									
25b. REGISTRAR'S SIGNATURE Charles Judge														

14307

14313

Prince Georges

Maryland

St. Paul

RURAL-Upper Marlborough 16 yrs. RURAL-Upper Marlborough

Johnson Farm, Box 2338

Chelsoe Farm, Box 2338

Dean

Henric

October 20, 07

White

Jan. 10, 1908

Tobacco Raising

Tenant

Unknown

Unknown

Unknown

Unknown

Anna Henric - Same as Item 14313

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Handwritten signature

Dr. Robert A. Sanner, M.D., Upper Marlborough, Md. 20670

Box 1 10/20/07 Washington Md. 20001

Rural Box 1 Upper Marlborough, Md.

Oct 20 1907

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14309

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14314

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. LENGTH OF STAY IN tb 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greenbelt Nursing Home				d. STREET ADDRESS 620 Pershing Drive 10120 New Hampshire Ave.		15-2	
3. NAME OF DECEASED (Type or print) Cornelia A. Holmead				4. DATE OF DEATH Month 10 Day 26 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 8-5-1883		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 26 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Holmead				14. MOTHER'S MAIDEN NAME Alice G. Unkle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-62-8430		17. INFORMANT 10120 New Hampshire Ave. Nellie Fowler Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 420.0 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of right hip - 9-26-67						INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at Nursing home					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:00am p.m. 9-26- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Green belt Nursing Home, Greenbelt, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 10-27-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 31, 1967		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR C. Glen Carter				25a. REC'D BY REGISTRAR NOV 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
Warner E. Pumphrey, Inc. Silver Spring, Md.							

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 25 days 14 1/2 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 3404-39th Place 20722	
3. NAME OF DECEASED (Type or print) Austin M. Holtzelaw		4. DATE OF DEATH Month October Day 17 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/18/01
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Holtzelaw, Luther J.		14. MOTHER'S MAIDEN NAME Cortez, Tacy Emmia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-24-9457	
17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO MULTIPLE MYELOMA (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-21 , 19 67 , to 10-17 , 19 67 , that (I) (we) last saw the deceased alive on 10-16 , 19 67 , and that death occurred at 2 A.M. , from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 10-17-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN		22d. ADDRESS RIVERDALE MD.	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 10/18/67	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City or Town) (County) (State) Leesburg Va.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR Oct 19 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATEMENT OF FACTS

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Geo. Forestville</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville Md.</u>		c. LENGTH OF STAY IN 1b <u>16-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Rehab. Center</u>		d. STREET ADDRESS <u>5820 Reed St.</u>	
3. NAME OF DECEASED (Type or print) <u>Leroy</u> First Middle Last <u>HOWARD</u>		4. DATE OF DEATH <u>October 27</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-04</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John HOWARD</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE DOWNING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Bessie HOWARD-wife-5820 Reed St.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA - pulmonary collaps.</u> DUE TO (b) <u>Ca of lungs (metastatic)</u> DUE TO (c) <u>Obstruction of airway.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1960</u> <u>1967</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-25-1967</u> to <u>10-27-1967</u> that (I) (we) lost saw the deceased alive on <u>10-26-1967</u> , and that death occurred at <u>330</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Reed</u>		22b. DATE SIGNED <u>10-27-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Maryland</u>
24. FUNERAL DIRECTOR <u>John T. Stewart Jr.</u>		25a. REC'D BY REGISTRAR <u>10 OCT 30 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
Stewart Funeral Home-4001 Benning Rd.,			

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE c. LENGTH OF STAY IN 1b 3 HRS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CALVERT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORTH BEACH d. STREET ADDRESS RT 1, BOX 254 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMMA First Middle Last L HUARD				4. DATE OF DEATH Month Day Year OCTOBER 26 19 67			
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Nov 1921	
9. AGE (In years last birthday) 45 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) RICHMOND, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME ALLEN HARLOW			
14. MOTHER'S MAIDEN NAME OLLIE MAE ROBINSON				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA UNK			
16. SOCIAL SECURITY NO. UNK				17. INFORMANT Robert F. Huard Address HUSBAND SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO probable myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 hours DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) unknown							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from 26 Oct, 1967 , to 26 Oct, 1967 , that (I) (we) last saw the deceased alive on 26 Oct 1967 , and that death occurred 0230AM , from causes and on the date stated above.							
22a. SIGNATURE Louis G. Martin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 26 Oct 67	
22c. PHYSICIAN'S NAME (Type) LOUIS G. MARTIN, CAPT, USAF, MC				22d. ADDRESS Malcolm Grow USAF Hospital Andrews AFB, Wash DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR W.W. Chambers, Co. Inc.				517 ADDRESS 11th St. S.E. Washington, D.C.		25a. REC'D BY REGISTRAR NOV 1 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN b. 7 days, 10hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland d. STREET ADDRESS 3121 Madison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Laura Mae Iager First Middle Last		4. DATE OF DEATH October 12 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/12
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm H Thomas		14. MOTHER'S MAIDEN NAME Elizabeth Turnbull	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577 01 3719	
17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5810 IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 M.O.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Gastritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-22 , 19 57 to oct 12 , 19 67 , that (I) (we) last saw the deceased alive on oct 11 , 19 67 , and that death occurred at 1:30 M, from causes on and the date stated above.			
22a. SIGNATURE L W MALIN M.D.		22b. DATE SIGNED 10/13/67	
22c. PHYSICIAN'S NAME (Type) L W MALIN MD.		22d. ADDRESS Riverdale, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 14, 1967	
23c. NAME OF CEMETERY OR CREMATORIUM George Washington		23d. LOCATION (City or town) (County) (State) Hyattsville Pro Geo Md.	
24. FUNERAL DIRECTOR Loach's Funeral Home - 4729 Belts Ave. N		25a. REC'D BY REGISTRAR OCT 16 1967	
ADDRESS Hyattsville		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G394 11/13/67 pb

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville d. STREET ADDRESS 6118 Odell Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Jackson		4. DATE OF DEATH Month Day Year Oct. 7, 1967				
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 17-1875	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days 16	IF UNDER 24 HRS. Hours Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard		11. BIRTHPLACE (County & State, or foreign country) Glendale Md		12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME Austin Jackson		14. MOTHER'S MAIDEN NAME Charlotte Mathews				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Elsie Crump Address Same as 2D		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Essential Hypertension (c) 10/yr 15 yrs						INTERVAL BETWEEN ONSET AND DEATH 12
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIVERTICULOSIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from 10-11-67 , to Oct. 7, 1967 , that (I) was saw the deceased alive on 19 , and that death occurred at 10:50 , from causes and on the date stated above.						
22a. SIGNATURE Henry A. Wise, Jr., M.D.		22b. ADDRESS 13008-9th Street, Bowie, Md. 20715		22c. DATE SIGNED AM ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-11-67		23b. DATE THEREOF 10-11-67		23c. NAME OF CEMETERY OR CREMATORY Glendale Cem.		23d. LOCATION (City or Town) (County) (State) Glendale, Md
24. FUNERAL DIRECTOR Henry S Washington & Sons		ADDRESS 4925 Deane ave SE		25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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DEPARTMENT OF STATE

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy Suzanne Johnson		4. DATE OF DEATH 10-13-67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) 32 38 yrs.
9. DATE OF BIRTH 4-1-29		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tunist		10b. KIND OF BUSINESS OR INDUSTRY N A S A	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Reginald William Smith		14. MOTHER'S MAIDEN NAME Dorothy Shand	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Mr. William F. Smith		18. ADDRESS 901 Northampton Dr. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cause undetermined DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 10-14-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		23. NAME OF CEMETERY OR CREMATORY George Washington Cem.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 17, 1967	
23c. LOCATION (City or Town) (County) (State) Hyattsville, Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR'S NAME Warner C. Humphrey, Inc.		25. REC'D BY REGISTRAR OCT 19 1967	
25a. ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14316

CERTIFICATE OF DEATH

14321

1. PLACE OF DEATH a. COUNTY <u>County Prince George</u> <u>Pine View GARDENS</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>				c. LENGTH OF STAY IN 1b <u>9/12/67-10-1-67</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE VIEW GARDENS</u>				d. STREET ADDRESS <u>6902 PINE DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Johnson</u> Last <u></u>				4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-26-01</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>				13. FATHER'S NAME <u>JAMES HENRY CONROY</u>			
14. MOTHER'S MAIDEN NAME <u>VIRGINIA PAINE SANFORD</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N/A</u>			
16. SOCIAL SECURITY NO. <u>230-03-6053</u>				17. INFORMANT <u>VIRGINIA SLEZAK - same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO <u>Cerebrovascular hypertension disease 2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis advanced</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-2</u> , 19 <u>67</u> to <u>10-1</u> , 19 <u>67</u> and that death occurred on <u>10-1</u> , 19 <u>67</u> , and that death occurred at <u>12:45 PM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Alfred R. Lapin, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>				22d. ADDRESS <u>CLINTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Oct. 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Providence Meth.Ch.Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Montrose, Virginia</u>	
24. FUNERAL DIRECTOR <u>W R Sanford Sanford Funeral Home</u>				ADDRESS <u>Montrose Va</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 25 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CONTINUATION OF DATA

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Pr. George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>P. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Hghts., Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Rehabilitation Center</u>		d. STREET ADDRESS <u>902 59th XXXXX Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Roxie</u> First <u>Jones</u> Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-6-84</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>12</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>XXXXX Louis Shellman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lottie Skipper</u>		Address <u>902-59th Ave.,</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Rt Upper Lobe</u> DUE TO <u>C.V.A. & Rt Hemiparesis & Tracheostomy 9 wks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/6/67</u> to <u>10/12/67</u> , that (I) (we) last saw the deceased alive on <u>10/12/67</u> , and that death occurred at <u>8:30 PM</u> from causes and on the date stated above.		22a. SIGNATURE <u>Kelvin L Minchin</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>10/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KELVIN L MINCHIN</u>		22d. ADDRESS <u>6400 MARLBOROUGH PIKE SE WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-17-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Landon Md.</u>	
24. FUNERAL DIRECTOR <u>Rollins Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>4339 Munt NE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 16 1967</u>			

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14318 CERTIFICATE OF DEATH 14323									
1. PLACE OF DEATH a. COUNTY Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY #203				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 15 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Maryland				16-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 1720 Brightseat Rd. #203			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joanne		First Middle Last M Karmel		4. DATE OF DEATH Month Day Year October 24, 1967 19					
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/3/47		9. AGE (In years last birthday) yrs. 20		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Earl J Thompkinson					14. MOTHER'S MAIDEN NAME Irma L Witten				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Donald L Karmel Landover, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis 201x DUE TO (b) Perforation of Stomach - Fundus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hodygkins Lymphoma Stomach								INTERVAL BETWEEN ONSET AND DEATH 3 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 1967, to 24 Oct 1967, that (I) (we) last saw the deceased alive on 24 Oct 1967, and that death occurred on 2:15 P.M. from causes and on the date stated above.									
22a. SIGNATURE Thomas M. Hutchins					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) Dr. Thomas M. Hutchins					22d. ADDRESS 7315 Landover Rd., Landover, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 27, 1967		23c. NAME OF CEMETERY OR BURIAL Washington National		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE OCT 30 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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STATEMENT OF CLAIM

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Prince George General Hospital

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14319 Item #11 Film #G 14324 CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 2 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4310 Kaywood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Kelly					4. DATE OF DEATH Month Day Year Oct. 17, 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 17, 1967		9. AGE (In years last birthday) 16-1 IF UNDER 1 YEAR Months Days Hours Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Cheverly, P.G. Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Lidden Kelly					14. MOTHER'S MAIDEN NAME Janet Lorsey Lindell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity, 600 mgs. DUE TO (b) Primary atelectasis of lungs, bilateral DUE TO (c) Cephalohematoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) this hospital attended the deceased from Oct. 17, 1967 , to Oct. 17, 1967 , that (I) see saw the deceased alive on Oct. 17, 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above.									
22a. SIGNATURE Harry E. Altman					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Oct. 19, 1967		
22c. PHYSICIAN'S NAME (Type) Harry E. Altman, M. D.					22d. ADDRESS 2025 Eye St., NW, Washington, D. C. 20006				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10-21-67		23c. NAME OF CEMETERY OR CREMATORY Prince George's Hospital		23d. LOCATION (City or Town) (County) (State) Cheverly, Md.			
24. FUNERAL DIRECTOR HARRY W. DENN, JR., Cheverly, Md.					25a. REC'D BY REGISTRAR ACT 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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DEPT. OF JUSTICE

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 20 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Keola		4. DATE OF DEATH Month 10 Day 18 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-9-1919
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Eng.	
11. BIRTHPLACE (State or foreign country) HAWAII		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM K. KEOLA		14. MOTHER'S MAIDEN NAME MATILDA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 575-05-8398	
17. INFORMANT Anne L. Keola		Address Wife Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 10-18-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10-21-67	
23c. NAME OF CEMETERY OR CREMATORY William M. MoxTuary		23d. LOCATION (City or Town) (County) (State) Honolulu Hawaii	
24. FUNERAL DIRECTOR GASCH'S		25a. REC'D BY REGISTRAR OCT 23 1967	
25b. REGISTRAR'S SIGNATURE HYATTSVILLE, MD.		25c. REGISTRAR'S SIGNATURE John Kehoe	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Deputy Med. Exam., Dr. John Kehoe Notified and Released.

VR A15 (4)
25M 1/67

jwb

14321												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												14326			
1. PLACE OF DEATH a. COUNTY Pr. Geo. MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN Tb D. O. A.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor						16-1									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.												d. STREET ADDRESS 3506 37th Ave.												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First HELEN Middle KIDWELL Last												4. DATE OF DEATH Oct. Month 23 Day 19 Year 67															
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/5/11		9. AGE (In years last birthday) yrs. 56		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Checker				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.															
13. FATHER'S NAME James M. Armiger								14. MOTHER'S MAIDEN NAME Lelia M. Wood																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 217 26 5214				17. INFORMANT Florence W. Kidwell				Address Same as # 2															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																			
21. I certify that (I) (this hospital) attended the deceased from 1952 , to Oct 22 1967 , that (I) had last saw the deceased alive on Oct 22 1967 , and that death occurred at 8:00 PM , from causes and on the date stated above.																											
22a. SIGNATURE Robert Wingfield												22b. DATE SIGNED 10/24/67															
22c. PHYSICIAN'S NAME (Type) Robert Wingfield				22d. ADDRESS Laurel, Md.																							
23a. BURIAL, CREMATION, or other disposal (Specify) Burial				23b. DATE THEREOF 10/26/67				23c. NAME OF CEMETERY OR CREMATOR St. Thomas Church Ceme.				23d. LOCATION (City or Town) (County) (State) Pr. Geo. Md.															
24. FUNERAL DIRECTOR Francis Gasch's Sons								ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR OCT 30 1967				25b. REGISTRAR'S SIGNATURE Charles Judge											

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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• 54 • Journal

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14322 CERTIFICATE OF DEATH 14327

1. PLACE OF DEATH a. COUNTY Prince Georges Co.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor Nursing Home		d. STREET ADDRESS 3300 Connecticut Ave. N.W.	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ARTHUR KINGSTON		4. DATE OF DEATH Month Day Year 10-24-1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-1888
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. Kingston		14. MOTHER'S MAIDEN NAME Alice Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 579-34-3686	
17. INFORMANT Mrs. Edwin A. Rankin-3040		Address Wash.D.C. Legation St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE PENIS c 1790 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED METASTASES DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-29, 1965, to 10-24, 1967, that (I) (we) last saw the deceased alive on 10-23, 1967, and that death occurred at 7:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Thomas F Collins		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) THOMAS F. COLLINS		22d. ADDRESS 332 H 21 NE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-27-1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery	23d. LOCATION (City, town or county) (State) Arlington, Va.
24. FUNERAL DIRECTOR Joseph gawler's sons, Inc.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
ADDRESS 5130 wisg. Ave. N.W. Wash. D.C.		DATE OCT 26 1967 Charles Judge	

1932

Prince George No.

May 1st

1932

Prince George No.

May 1st

1932

May 1st

1932



1932

14323

CERTIFICATE OF DEATH

14328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>47-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Manor 4722 LaSalle Road</u>		d. STREET ADDRESS <u>1415 OTIS STREET N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Marie A. KINZELMAN</u>		4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/78</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carl E. Happel</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Schmitt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-661161</u>	
17. INFORMANT <u>Sen. M. Regis</u>		Address <u>Carroll Manor</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>+ Arterio-sclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential hypertension, benign; Osteo-arthritis, general, mild</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u> </u> , to <u>Oct 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 26, 1967</u> , and that death occurred at <u>7:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Chas. F. Brennan</u>		22b. DATE SIGNED <u>Oct 27/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Wheaton, Maryland</u>
24. FUNERAL DIRECTOR <u>Jas. T. Ryan, Inc.</u>		25a. SEND BY REGISTRAR DATE <u>OCT 31 1967</u>	
ADDRESS <u>317 Pa. Ave., SE DC3</u>		25b. REGISTRAR'S SIGNATURE <u>Charles George</u>	

1933

RECORD OF DEATH

1933

1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b two days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 8508 63rd Ave.	
3. NAME OF DECEASED (Type or print) Tuesnelde Wilhelmina Langley		4. DATE OF DEATH Month 10 Day 26 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/30/85
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Ret.		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Koepper, Adolph		14. MOTHER'S MAIDEN NAME Whitram, Carlina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Foster, Eleanor		Address Berwyn Heights, 8508 63rd Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis (R) = left DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 14 67 to Oct 16 67 , that (I) (we) last saw the deceased alive on Oct 16 67 , and that death occurred at 4:50 M, from causes and on the date stated above.			
22a. SIGNATURE W. L. Etienne		22b. DATE SIGNED 10/16/67	
22c. PHYSICIAN'S NAME (Type) W. L. ETIENNE		22d. ADDRESS College Park Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 30, 1967	
23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City or town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR W. W. CHAMBERS CO		25b. REGISTRAR'S SIGNATURE Charles Judge	
ADDRESS Riverdale, Md		DATE NOV 1 1967	

1-1-1950

DEPARTMENT OF HEALTH

1-1-1950

James Gordon

Washington

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January 1950

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Grand Memorial Hospital

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23

Homestead - Nat. As. House

Baltimore, Maryland

and Mrs. Corbin

No. 10

Unknown

Carroll Thompson (R) 5 left

Handwritten signature/initials

copy of letter to

copy of letter to
Mr. E. J. Evans

Called to talk with

Initial Oct. 30, 1950 Congressional Cemetery Washington, D. C.
N. W. CHAMBERS CO. Riverdale, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14325

Items #c & d Film #G390 11/16/67 mh
Item 2C Film G390 11/21/67 RA

CERTIFICATE OF DEATH

14330

1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>New Carrollton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens</u> <u>9104 Good Luck Rd</u> <u>LANHAM</u>		d. STREET ADDRESS <u>6117 86th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Theresa MARIE LAW</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16 - 1892</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DANBURY - CONN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD Henry</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET BRENNAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>EDGAR LAW SON</u>		Address <u>6117 - 86th AVE.</u> <u>New CARROLLTON, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>coronary heart disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>66</u> to <u>10/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/15</u> , 19 <u>67</u> , and that death occurred at <u>5:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leon R. Levitsky</u>		22b. DATE SIGNED <u>OCT. 15 - 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky</u>		22d. ADDRESS <u>3408 R.I. Ave. Mt. Rainier, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-19-67</u>	
23c. NAME OF CEMETERY <u>LAKEVIEW</u>		23d. LOCATION (City or Town) (County) (State) <u>Bridgeport, Conn.</u>	
24. FUNERAL DIRECTOR <u>Gaschi's</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Hyattsville, Md.</u>		DATE <u>OCT 19 1967</u>	

650

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14326

14331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>417 Madison Street N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Madison Manor Nursing Home 5801 52nd Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>D.</u> Last <u>Lawrenson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 2, 1887</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Karl Dorman</u>				14. MOTHER'S MAIDEN NAME <u>Rosa E. Edwards</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>578-62-3208</u>		17. INFORMANT <u>Mrs. Frances L. Pitman</u>		Address <u>417 Madison St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>year</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>67</u> to <u>10-21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-17</u> , 19 <u>67</u> , and that death occurred at <u>6:45</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald C. Edgner</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD C. EDGNER</u>				22d. ADDRESS <u>Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey Inc.</u>				ADDRESS <u>8434 Georgia Avenue S.E.</u>		25a. REC'D BY REGISTRAR <u>OCT 26 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1934

STATE OF NEW YORK

1934

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "and", "the", "of" are visible.]

[Faint text at the bottom of the page, possibly a signature or date.]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
c. LENGTH OF STAY IN lb 3 hrs.		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 6213 Kennedy St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Idella Lee		4. DATE OF DEATH Month Day Year 10 5 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1898
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 10 5 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Fuller		14. MOTHER'S MAIDEN NAME Martha Ashe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Betty Massey - 6213 Kennedy Street		Address E. Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral vascular occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH over 2 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-6-67	
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/11/67	
23c. NAME OF CEMETERY OR CREMATORY CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) BAINBRIDGE, GA.	
24. FUNERAL ADDRESS JOHN T. RHINES CO. FUNERAL HOME, 3015 12TH ST.		25a. REC'D BY REGISTRAR OCT 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

582

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14333

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u>		d. STREET ADDRESS <u>Hillside</u>	
3. NAME OF DECEASED (Type or print) <u>Myra Christine Liverette</u>		4. DATE OF DEATH <u>10 14 19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 June 1917</u>
9. AGE (In years last birthday) <u>50 yrs.</u>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Schaefer</u>		14. MOTHER'S MAIDEN NAME <u>Susie Sutherland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Harry E. Liverette Same As # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4200</u> IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>over 1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u>		22. DATE SIGNED <u>10-14-67</u>	
EXAMINER'S NAME (Type) <u>John Kehoe, MD, Riverdale, Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/17/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Prince Georges, Md</u>	
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>		25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>	
4308 Suitland Road, Suitland, Maryland		25b. REGISTRAR'S SIGNATURE <u>Richard S. Suckel</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14329

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14334

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xxx Beltsville		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 11129 Emack Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl J. Lombard				4. DATE OF DEATH Month 10 Day 25 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Nov. 1912		9. AGE (In years lost birthday) yrs. 54	10. IF UNDER 1 YEAR Months 10 Days 25 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Lawyer		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ? Lombard				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W W 11		17. INFORMANT Frances F Lombard		Address Beltsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH minutes over 1 mo.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 10-26-67		22. DATE SIGNED 10-26-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven cemetery		23d. LOCATION (City or Town) (County) (State) Wheaton Montgomery Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR OCT 30 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

1938

1938

UNITED STATES DEPARTMENT OF STATE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

January 1, 1938

Dear Sir:

Dear Sir:

I am very pleased to hear

I am very pleased to hear

from you and hope you are

from you and hope you are

well and happy.

well and happy.

Very truly yours,

Very truly yours,

John H. Johnson

John H. Johnson

Enclosed for you are

Enclosed for you are

two copies of the

two copies of the

report of the

report of the

committee on

committee on

the subject of

the subject of

the proposed

the proposed

amendment to

amendment to

the constitution

the constitution

of the United

of the United

States.

States.

I am, Sir,

I am, Sir,

Very truly yours,

Very truly yours,

John H. Johnson

John H. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14330

14335

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5506 Shadyside Ave.	
3. NAME OF DECEASED (Type or print) Mildred L. Long		4. DATE OF DEATH Month Oct. Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/16
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE AT HOME	
11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM E. SUMMERS		14. MOTHER'S MAIDEN NAME KATE V. WATSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE		16. SOCIAL SECURITY NO. 578-10-3886	
17. INFORMANT LEON T. LONG		Address SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) advanced cancer of the cervix with metastasis DUE TO (b) (heavy vaginal bleeding) DUE TO (c) 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/18 , 19 67 , to 10/13 , 19 67 , that (I) (we) last saw the deceased alive on 10/13 19 67 , and that death occurred at 3:40P M, from causes and on the date stated above.			
22a. SIGNATURE F. Kazemi		22b. DATE SIGNED 10/13/67	
22c. PHYSICIAN'S NAME (Type) Farizar Kazemi		22d. ADDRESS Prince George's General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/17/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.
24. FUNERAL DIRECTOR W. W. Chamber, Inc.		25a. REC'D BY REGISTRAR OCT 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14331

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14336

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		13-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS RFD 1, Old Montgomery Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Donald Ernest Lorenz		4. DATE OF DEATH Month 10 Day 18 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-1924
9. AGE (In years lost birthday) 43 yrs.		IF UNDER 1 YEAR Months 13 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINT. MAN		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALFRED M. LORENZ		14. MOTHER'S MAIDEN NAME ALICE HANNEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 218-126741	
17. INFORMANT ELEANORA M. LORENZ		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemo-peritoneum 9365 DUE TO Laceration of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Undetermined	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:45am 10-18 1967		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 12705 Cedraville Lane, Laurel, P.G.		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-19-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/21/67	
23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S LUTHERAN		23d. LOCATION (City or Town) (County) (State) HOWARD CO. MD.	
24. FUNERAL DIRECTOR E.S. MACNABB		25a. REC'D BY REGISTRAR 301 FREDERICK RD	
25b. REGISTRAR'S SIGNATURE 21272		DATE OCT 23 1967	

1883


14727-11

1883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
20M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
14332					14337														
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)														
a. COUNTY Prince George's					a. STATE Maryland														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine					b. COUNTY Pr. Geo.														
c. LENGTH OF STAY IN 1b 17 years					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS Rt. 1-Box 394														
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month			Day			Year							
First Clines			Middle L.			Last Lyles			October			28							
5. SEX Male			6. COLOR OR RACE Negro			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH May 10, 1902			9. AGE (In years last birthday) 65 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) Newbury, S. Carolina					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME William Lyles					14. MOTHER'S MAIDEN NAME Unknown														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Lottie Lyles					Address Same				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Damage to heart valve and aorta (c) Gout										INTERVAL BETWEEN ONSET AND DEATH 1D y									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 10-12, 1956, to 10-28, 1967, that (I) (we) last saw the deceased alive on 10-26, 1967, and that death occurred at 8:30 M, from the causes and on the date stated above.																			
22a. SIGNATURE 										22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) Martell Adams					22d. ADDRESS Aguasco, Maryland					22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Nov. 4/67					23c. NAME OF CEMETERY OR CREMATORY St. Thomas Ch. Cemetery					23d. LOCATION (City, town or county) (State) Brandywine, Maryland				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE Charles Judge									

VCCF

3850

1983

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 3 Film 3393, 10/20/67 Wc
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14333

14338

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 5015 Kirby Hill Road, #404-B	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Zebulun Zebulun Lash		4. DATE OF DEATH Month Day Year 10-13-67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-06
9. AGE (In years lost birthday) yrs. 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School administrator Prep. School	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kerr Duncan Macmillan		14. MOTHER'S MAIDEN NAME Cornelia Lash	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WWII		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife: Mrs. Jeannette Macmillan, Bluemont, Va.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH over 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus for over 10 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 10-14-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/67	
23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Berryville, Clarke, Va.	
24. FUNERAL DIRECTOR JOHN H. ENDERS FUNERAL HOME		25. REC'D BY REGISTRAR DATE OCT 17 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Enders		25c. REGISTRAR'S SIGNATURE Charles J. Enders	

1333

1333



MAILED

APR 14

Handwritten signature or initials.

Handwritten text at the bottom of the page, possibly a date or reference.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1000-P. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Patricia Marie Marietta		4. DATE OF DEATH Month Day Year 10 15 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Nov., 1938
9. AGE (In years lost birthday) 28 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PSYCHOLOGY TEACHER MD. UNIVERSITY		10b. KIND OF BUSINESS OR INDUSTRY PENN A	
11. BIRTHPLACE (State or foreign country) PENN A		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME VICTOR MARIETTA JR		14. MOTHER'S MAIDEN NAME MARGARET HAUSMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT VICTOR MARIETTA, JR.		18. ADDRESS SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9702 IMMEDIATE CAUSE (a) Intoxication-barbiturates DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Took overdose of nembutal.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. unknown 10-13-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Same as #2	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		22. DATE SIGNED 10-15-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Oct 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY ST. EDWARDS CEM		23d. LOCATION (City or Town) (County) (State) SHAMONIN, PENN A.	
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md		25a. REC'D BY REGISTRAR DATE OCT 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

John Kehoe, M.D., Riverdale, Md.

BURIAL Oct 19, 1967 ST. EDWARDS CEM SHAMONIN, PENN A.
W.W. Chambers Co. Riverdale, Md
OCT 18 1967 Charles Judge

100

128 X 1700

100-44173

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14335

14340

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Cheverly			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN tb 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 2239 12th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Robert Last Marshall				4. DATE OF DEATH Month 10 Day 20 Year 1967			
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 Mar., 1942	
9. AGE (In years last birthday) yrs. 25		IF UNDER 1 YEAR Months 25 Days 19 Hours 67 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of last year) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME James Marshall				14. MOTHER'S MAIDEN NAME Rosetta ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Rosetta Marshall Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO (b) Post surgical, 11 days - Laceration of liver DUE TO (c) Gunshot wound of abdomen INTERVAL BETWEEN ONSET AND DEATH 11 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Shot following altercation							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot following altercation			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:45 am 10-9 1967				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Takoma Park (City or town) (County) (State) street in front of 951 E-W Highway P.G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe				22. DATE SIGNED 10-22-67			
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 10/26/1967		23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City or Town) (County) (State) Landover, Maryland	
24. FUNERAL DIRECTOR W. Ernest Jarvis Co., Inc.				25a. REC'D BY REGISTRAR DATE OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Section 1

Section 2

Section 3

Section 4

Section 5

Section 6

Section 7

W. E. Smith & Co., Inc. 1000 York St., N.Y. OCT 24 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate shall be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Continued from Page 1 of 2
Prince Georges County, Md.

VR A15
15M 7/67

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1-1341											
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY in tb <u>5 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				d. STREET ADDRESS <u>3209 Toledo Place Hyattsville, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3209 Toledo Place, Hyattsville, Md.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Frederick Thomas Martin</u>						4. DATE OF DEATH <u>October 5 1967</u>		Month <u>October</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 24, 1918</u>		9. AGE (In years last birthday) <u>49 yrs.</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rutherford County, N.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas P. Martin</u>						14. MOTHER'S MAIDEN NAME <u>Dovie Scoggins</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>267-05-9513</u>		17. INFORMANT <u>Mrs. Sudia Martin</u> Address <u>3209 Toledo Pl. Hyattsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Esophageal Varices</u> 5210 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Cirrhosis</u> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (1) (this hospital) attended the deceased from <u>October 5, 1967</u> to <u>Oct. 5, 1967</u> , that (1) (we) last saw the deceased alive on <u>9am, Oct 5, 1967</u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert A. McCormick</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/5/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert A. McCormick</u>						22d. ADDRESS <u>11161 New Hampshire Ave. Silver Sp., Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baptist Church Cemetery</u>		23d. LOCATION (City, town or county) <u>Manchester Carroll Co. Md.</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.S. Myers Jr., Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>OCT 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HILCREST HEIGHTS					c. LENGTH OF STAY IN 1b 6 YRS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2108 KEATING ST HILCREST HTS MD					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ERNEST Middle MERRICK Last MASON					4. DATE OF DEATH Month 10 Day 17 Year 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/4/03		9. AGE (In years last birthday) 64 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER		10b. KIND OF BUSINESS OR INDUSTRY DC TRANSIT		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON DC		12. CITIZEN OF WHAT COUNTRY? US				
13. FATHER'S NAME JOHN THOMAS MASON					14. MOTHER'S MAIDEN NAME MARGARET ELIZABETH HURRIGAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					16. SOCIAL SECURITY NO. 1919-1920 578-10-8396		17. INFORMANT MRS M. MERRITT Address HILCREST HTS 2108 KEATING ST MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) METASTATIC BRONCHIOGENIC CARCINOMA DUE TO (c) 2 YRS									INTERVAL BETWEEN ONSET AND DEATH 24 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) this hospital, attended the deceased from 10/13 , 19 65 , to 10/17 , 19 67 , that (1) we last saw the deceased alive on 10/16 , 19 67 , and that death occurred at 9 AM , from the causes and on the date stated above.										
22a. SIGNATURE Raymond W Turner					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/67			
22c. PHYSICIAN'S NAME (Type) RAYMOND W TURNER					22d. ADDRESS 2121 PENN AVE NW WASH DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 20-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City, town or county) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Simmons Bros.					ADDRESS 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR OCT 20 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

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Oct 30 1961

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1100 N. Stafford Street	
3. NAME OF DECEASED (Type or print) First Middle Last David I. Massing		4. DATE OF DEATH Month Day Year 10 29 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/1942
9. AGE (In years lost birthday) 25 yrs.		10. IF UNDER 1 YEAR Months Days Hours 25 yrs.	
11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Massing		14. MOTHER'S MAIDEN NAME Ann Phipps	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 232-70-4576	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8164 IMMEDIATE CAUSE (a) Hemorrhagic shock DUE TO Laceration of neck Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma - auto accident DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1:30am 10-29-19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. Rt. 210, Accokeek, Maryland		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 10-30-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/1967	
23c. NAME OF CEMETERY OR CREMATORY Huse Mem. Park Cem.		23d. LOCATION (City or Town) (County) (State) Fayettesville, W.Va.	
24. FUNERAL DIRECTOR Home Inc. Nalley's Funeral ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR DATE OCT 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14339

14344

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3708 Bladensburg Road	
3. NAME OF DECEASED (Type or print) First Middle Last Forest Earl Mathers		4. DATE OF DEATH Month Day Year Oct. 5, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/ 1915
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Sta. Att.		10b. KIND OF BUSINESS OR INDUSTRY Home Oil Co.	
11. BIRTHPLACE (County & State, or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Mathers		14. MOTHER'S MAIDEN NAME Flossie Smarr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. WWTT	
17. INFORMANT Mrs. Ruby P. Mathers (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stenosing coronary arteriosclerosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Budding emphysema and severe congestion of lungs bilateral DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 9-25 , 19 67 , to Oct. 5, 19 67 , that (I) (we) saw the deceased alive on 19 , and that death occurred on 10:15 AM , from causes and on the date stated above.		22a. SIGNATURE George J. Hageage M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED AM		22c. PHYSICIAN'S NAME (Type) George J. Hageage, M. D.	
22d. ADDRESS 3717 38th Ave. Cottage City, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 10/8/67		23c. NAME OF CEMETERY OR CREMATORY Beech Valley Cem.	
23d. LOCATION (City or Town) (County) (State) Beech Valley, W. Va.		24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.	
25a. REC'D BY REGISTRAR DATE OCT 9 1967		25b. REGISTRAR'S SIGNATURE Charles J. J. J.	

12-11-41

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EXHIBIT OF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Georges' County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN lb <u>2 mos 11 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRYANS ROAD</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care Center</u>		d. STREET ADDRESS <u>RT 1 Box 4</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JAMES J. MCCARTHY</u>		4. DATE OF DEATH <u>10-26-1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-29-1969</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	9. AGE (In years lost birthday) <u>98 yrs.</u>
13. FATHER'S NAME <u>ANDREW MCCARTHY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>ANNA TAYLOR</u>	
16. SOCIAL SECURITY NO. <u>212-56-0792</u>		17. INFORMANT <u>MRS. A.R. Guisinger, Bryans Rd., MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>7824</u> IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY COLLAPSE</u> DUE TO (b) <u>GENERALISED WEAKNESS</u> DUE TO (c) <u>SENILITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "o.m." p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>62</u> , to <u>10-26</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>10-26</u> 19 <u>67</u> , and that death occurred at <u>9:45M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-26-67</u>
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>OCT 27 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>
24. FUNERAL DIRECTOR <u>HUNT FUNERAL HOME, WILDORE, MD.</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1000

OFFICE OF THE

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Clinton

Five Van Cortlandt Health Center, N.Y. 10027

JAMES

MCCARTHY

10-20

MALE WHITE

2-24-1924 48

CONTRACTOR

NEW YORK

ANDREW

MCCARTHY

ANNA TAYLOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
14341									
14346									
1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>					d. STREET ADDRESS <u>2853 Ontario Road, N.W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> First Middle Last					4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 24, 1901</u>		9. AGE (In years lost birthday) <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service-Clerk (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas Escue Means</u>					14. MOTHER'S MAIDEN NAME <u>Annie Ferguson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>577-07-5517-A</u>		17. INFORMANT <u>Edward Means - Son Sunnyvale, Cal.</u> Address <u>1020 Thistle Ct.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>Sarcoma of uterus - recurrent 20 years</u> 174X DUE TO <u>uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>10 days</u> (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>diabetes mellitus</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>10/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/3</u> 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>E H Markwood</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>10/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E H Markwood M.P.</u>					22d. ADDRESS <u>3208 - 17th NW</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>		
24. FUNERAL DIRECTOR <u>C. M. Travel</u> <u>Murphy Funeral Home,</u>					ADDRESS <u>Arlington, Virginia</u>		25a. REC'D BY REGISTRAR DA <u>OCT 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

1938

DEPARTMENT OF STATE

1938

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

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Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

Mr. [illegible]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14347

FOR STATE
HEALTH DEPT.

14342

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 1 1/2 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6511 Highland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond Thomas Medlin		4. DATE OF DEATH Month 10 Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 July 1924
9. AGE (In years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Pet Shop	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Redford Thomas Medlin		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 578-38-5927	
17. INFORMANT Mrs. Barbara Medlin, Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 979X DUE TO Occlusion of mouth and nose by plastic bag Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Put plastic bag over head			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Put plastic bag over head	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 11:30am m. 10-25-1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-26-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 10-26-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF OCT 30/1967	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATL CEM.		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE NOV 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4342

Is Yes.

Medlin

U.S.A.

Minnesota

Pat Shop

January

Unknown

Rebecca Thomas Medlin

Yes Korean 578-78-5927 Mrs. Barbara Medlin, born as 42

CERTIFICATE OF DEATH

14343

14348

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Ranier</u>	
c. LENGTH OF STAY IN lb <u>17 days</u>		d. STREET ADDRESS <u>2700 Arundel Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dorothy</u>		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 19, 1902</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>11</u> Hours <u>30</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nathan Wilner</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Kaplan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>052-09-7998</u>	
17. INFORMANT <u>William Nasoff</u>		Address <u>Same as 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>thrombotic heart disease</u> (b) <u>-----</u> DUE TO <u>-----</u> (c) <u>-----</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure (chronic)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/29/67</u> to <u>10/30/67</u> , that (I) (we) last saw the deceased alive on <u>10/29/67</u> , and that death occurred <u>6:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leon R. Levitsky, M.D.</u>		22b. DATE SIGNED <u>10/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky, M.D.</u>		22d. ADDRESS <u>3408 Rhode Island Avenue Mt. Ranier Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Wash. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hyattsville, Md.</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>NOV 1 1967</u>	
ADDRESS <u>4217 9th St., N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized in a table or form structure.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14344

14349

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1420 University Blvd.		d. STREET ADDRESS 1420 University Blvd.	
3. NAME OF DECEASED (Type or print) Margaret Alice Neele		4. DATE OF DEATH Month 10 Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 May 1908
9. AGE (In years lost birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3221 IMMEDIATE CAUSE (a) Inanition DUE TO Chronic alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-26-67	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10-27-67	
23c. NAME OF CEMETERY OR CREMATORY U of Md. Med. School		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE OCT 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11111

UNITED STATES DEPARTMENT OF AGRICULTURE

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OFFICE OF THE SECRETARY

WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14345													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
14350													
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERWYN							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE GENERAL HOSPITAL						d. STREET ADDRESS 5100 BERWYN ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER N. NEITZEY SR.						4. DATE OF DEATH Month Day Year OCT. 28 19 67							
5. SEX MALE		6. COLOR OR RACE CAU.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 March 1890		9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED (ELECTRICIAN)				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T		11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? US.			
13. FATHER'S NAME THOMAS H. NEITZEY						14. MOTHER'S MAIDEN NAME VIRGINIA DUTTON							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 216-09-9245		17. INFORMANT Address DOROTHY E. NEITZEY WIFE SAME AS #=2							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac Myocardial failure 4201 DUE TO Arteriosclerotic coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 to Oct 28 1967 , that (I) (we) last saw the deceased alive on Oct 25 1967 , and that death occurred at 11 A M, from causes and on the date stated above.													
22a. SIGNATURE W. L. Etienne						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/31/67					
22c. PHYSICIAN'S NAME (Type) W. L. Etienne						22d. ADDRESS Calleye Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/31/67		23c. NAME OF CEMETERY GEORGE WASHINGTON				23d. LOCATION (City or Town) (County) (State) HYATTSVILLE MD.					
24. FUNERAL DIRECTOR GASCH'S Funeral Home						ADDRESS HYATTSVILLE, MARYLAND		25a. REC'D BY REGISTRAR NOV 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

The Hyperbolic
 Curve
 of the
 Hyperbolic

W. L. E. Evans

College Park, Md.

CERTIFICATE OF DEATH

Reg. Dist. No. 14351

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY P G			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenarden			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				d. STREET ADDRESS 8614 Glenarden Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Clinton Newman				4. DATE OF DEATH 10 / 19 / 1967			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1888	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.C. Court				10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? Am.							
13. FATHER'S NAME John Albert Newman				14. MOTHER'S MAIDEN NAME Linker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO.		17. INFORMANT Ella Newman	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Carcinoma of Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to 10/19/67, that I last saw the deceased alive on 10/19/67, and that death occurred at 8:00 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry A. Wise, M.D.				DATE SIGNED 9:005 Oct 13 1967			
PHYSICIAN'S NAME (Type) Henry A. Wise, Jr.				ADDRESS (Street, city or town, state) 9005 Vol 13 St, Lanham, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-24-67		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE ROLLINS FUNERAL HOME, INC.				ADDRESS 4339 Hunt P Washington, D.C.		24a. REC'D BY REGISTRAR DATE OCT 23 1967	
				24b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

24746

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		White		1900		New York		1950		New York		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of informant		14. Relationship to deceased		15. Address of informant		16. City		17. State		18. Zip		19. Date of filing		20. Registrar's signature		21. Registrar's title		22. Registrar's office		23. Registrar's phone		24. Registrar's fax	
Jane Doe		Wife		123 Main St		New York		NY		10001		1950		[Signature]		Registrar		New York City		212-123-4567		212-123-4568	

12-20 This form is used for the purpose of recording the death of a person who is a resident of the State of New York. It is to be filled out by the physician or other qualified person who has attended the deceased, or by the informant who has the best knowledge of the facts. It is to be filed with the Registrar of Vital Statistics, New York City, or the Registrar of Vital Statistics, the State of New York, as the case may be. The form is to be filled out in duplicate, one copy to be retained by the Registrar and the other copy to be retained by the informant or other qualified person who has attended the deceased.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3309 Morelane Place	
3. NAME OF DECEASED (Type or print) First Emanuel Middle Robert Last Noel		4. DATE OF DEATH Month Oct. Day 6 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/29
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Engineer		10b. KIND OF BUSINESS OR INDUSTRY G S A	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Emanuel Richard Noel		14. MOTHER'S MAIDEN NAME Emily Hand	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 202 20 5445	
17. INFORMANT Devona E Noel		Address Bowie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VIRAL ENCEPHALITIS 0823 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO 1 month		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 9/3/67 , 19 67 , to Oct. 6 , 19 67 , that (I) (we) saw the deceased alive on Oct. 6 , 19 67 , and that death occurred at 5:15 PM , from causes on and on the date stated above.			
22a. SIGNATURE Roger B. Ingham M.D.		22b. DATE SIGNED 10/6/67	
22c. PHYSICIAN'S NAME (Type) Roger Ingham, M.D.		22d. ADDRESS 5701 85th Ave. Carrollton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR OCT 9 1967	
25b. REGISTRAR'S SIGNATURE J Charles Judge			

11-11-11

RECEIVED BY DEPT

11-11-11

Prince George

Prince George

Prince George

House

1 day

1 day

3300 Lawrence Place

Prince George General Hospital

Oct. 11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON, MARYLAND		c. LENGTH OF STAY IN 1b 6/30/67 10/2/67	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights, Maryland		d. STREET ADDRESS 59th Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PINE VIEW GARDENS HEALTH CARE CENTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Isabelle Delia North		4. DATE OF DEATH Month Day Year 10- 02 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-94
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Blackshen Ga.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James George Richard O'Neal		14. MOTHER'S MAIDEN NAME Smantha Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 261-18-3973	
17. INFORMANT ALFRED R. LAPIN, CLINTON, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY COLLAPSE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chachexia - Osteoarthritis DUE TO (c) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH 6 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1967 to 10-2 , 19 67 that (I) (we) last saw the deceased alive on 10-2 , 19 67 , and that death occurred at 12:28 PM, from causes and on the date stated above.			
22a. SIGNATURE Alfred R. Lapin, MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD		22d. ADDRESS CLINTON, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/7/67	
23c. NAME OF CEMETERY OR CREMATORY North Cemetery		23d. LOCATION (City or Town) (County) (State) Dupont, Georgia	
24. FUNERAL DIRECTOR Robert E. Wilhelm		25a. REC'D BY REGISTRAR 4398	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 6 1967	

WEST HALL OF DEATH

1937

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14349

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14354

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights DOD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1721 Addison Rd</u>		d. STREET ADDRESS <u>1767 Addison Rd</u>	
3. NAME OF DECEASED (Type or print) <u>REBECCA KAY PADGETT</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/14/58</u> 9. AGE (In years last birthday) <u>8</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lonnie W Padgett</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Ellen Syron</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Father Lonnie Padgett</u>		Address <u>1767 Addison Rd District Heights Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>External strangulation</u> DUE TO (b) <u>983 X</u> DUE TO (c) <u>While at work</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found apparently Strangled & Raped</u>	
21c. TIME OF INJURY Month <u>Oct</u> Day <u>7</u> Year <u>1967</u> Hour <u>3 AM</u>	21d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Unknown District Heights Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Daytono Watkins</u> M.O.		22. DATE SIGNED <u>10-7-67</u>	
EXAMINER'S NAME (Type) <u>DAYTONO WATKINS</u>		23. ADDRESS (Street, city, town, or county) <u>3655 GQ Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Abbey</u>	
23d. LOCATION (City or Town) (County) (State) <u>Savannah Ga.</u>		23e. RECORD BY REGISTRAR <u>OCT 11 1967</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers, Inc</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11-11-11

2432

11-11-11

CERTIFICATE OF DEATH

14355

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hill Crests Heights</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing Home</u>		d. STREET ADDRESS <u>18 Colebrook Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>-</u> Last <u>Papaleo</u>		4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-28-1960</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>I Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Vincenzio Papaleo</u>		14. MOTHER'S MAIDEN NAME <u>Maria DiBlasi</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Catherine Papaleo</u>		Address <u>18 Colebrook Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure Pneumonia</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ASHD, HCV D-</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-5</u> , 19 <u>67</u> , to <u>10-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-15</u> 19 <u>67</u> , and that death occurred at <u>12</u> M from causes and on the date stated above.			
22a. SIGNATURE <u>John F. Shay</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN F. SHAY</u>		22d. ADDRESS <u>5509 oed Silver Hill Rd Suitland, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Prince Georges, Md</u>
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>		25a. REC'D BY REGISTRAR <u>OCT 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1955

THIRD OF DECEMBER

1955

Mr. J. Edgar Hoover

Mr. J. Edgar Hoover

Director, FBI

Director, FBI

Washington, D.C.

Washington, D.C.

October 14, 1955

Popovich

Frank

1-28-1955

Male

I hereby

Shomshin

Walter Leland

Vincent Leland

Mr. Robert Popovich

10-2-55

OCT 14 1955
FBI - NEW YORK

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FBI - NEW YORK

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FBI - NEW YORK

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with ~~Page 3~~ Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

14351

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14356

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 12013 Tweed Lane,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ester Paperman				4. DATE OF DEATH 10-13 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 Sept 1892		9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PHILA. Pa		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME NORMAN ROSEN KRANTZ				14. MOTHER'S MAIDEN NAME SIMA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT SEMA GOTTIEB - 12013 TWEED LANE, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH Minutes Over 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus-over 30 yrs.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 10-13-67	
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE THEREOF 10-15-67		23c. NAME OF CEMETERY OR CREMATORY MT SHARON		23d. LOCATION (City or Town) (County) (State) CAN SPRINGFIELD DET. CO. PA.	
24. FUNERAL DIRECTOR Edman 2317 N. Broad St Phila Pa				25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
14352		CERTIFICATE OF DEATH		14357	
1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>None</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>		c. LENGTH OF STAY IN 1b <u>1 MONTH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALEXANDRIA</u> 83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDEN'S NURS. HOME</u>		d. STREET ADDRESS <u>117 W. REED AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY N. PAPIECK</u>		4. DATE OF DEATH Month Day Year <u>OCT. 31 19 67</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> (Unknown)	8. DATE OF BIRTH <u>1876</u>	9. AGE (In years lost birthday) yrs. <u>91</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>31 19 67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Steven Nacin</u>		14. MOTHER'S MAIDEN NAME <u>Rose (Unobtainable)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>231 70 3019 J1</u>		17. INFORMANT <u>Miss Pauline M. PapiECK</u> Address <u>117 W. Reed Ave. Alex., Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO (b) <u>urtemia</u> DUE TO (c) <u>pyelonephrit</u>				INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>10 days</u> <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> , 19 <u>67</u> to <u>Oct 31</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10/31</u> , 19 <u>67</u> , and that death occurred at <u>12</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dean R. Levitsky</u>		22d. ADDRESS <u>3408 Rhode Island Ave. MT Rainier</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4 Nov. 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Cecilia's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockaway, New Jersey</u>		
24. FUNERAL DIRECTOR <u>B. Eade Mountcastle</u>		ADDRESS <u>Cunningham Funeral Home Alex., Va.</u>		25a. REC'D BY REGISTRAR <u>NOV 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

1-1323

DEPARTMENT OF HEALTH

1-1323

1000

(Unknown)

At Home

At Home

House (Unknown)

House (Unknown)

117 N. Goodwin

221 to 2019 West "William W. Farnick" Alex. Va.

New Jersey

St. Cecilia's Cemetery, N. Jersey

Nov. 27

Continued from page 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14353

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14358

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 16100 Gerald Road extended				d. STREET ADDRESS 1103 XXXXXX Playford Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Castandinas Gus Pappas Jr.				4. DATE OF DEATH Month 10 Day 28 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-17-1949		9. AGE (In years last birthday) 18 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Prince Geo. Jr. Col.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Costandinas G. Pappas				14. MOTHER'S MAIDEN NAME Josephine Sprouse			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. yes		17. INFORMANT 1103 Address Playford Lane Costandinas G. Pappas Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9125 IMMEDIATE CAUSE (a) Asphyxia DUE TO Strangulation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crushed by lift mechanism of front end loader.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:15pm 10-28-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Same as # 1		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 10-30-67		22. DATE SIGNED 10-30-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 31, 67		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia	
24. FUNERAL DIRECTOR Walter C. Pumphrey, Inc.		24. FUNERAL DIRECTOR C. Glen Carter		25a. REC'D BY REGISTRAR NOV 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

2011

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2011-2012

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5322 28th Parkway	
3. NAME OF DECEASED (Type or print) Franklin A. Partin		4. DATE OF DEATH Month 10 Day 23 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-14
9. AGE (In years last birthday) 52 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District of Columbia Employee		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Partin	
14. MOTHER'S MAIDEN NAME Etla V. Neale		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 11	
16. SOCIAL SECURITY NO. WW 11		17. INFORMANT Dorothy A. Partin Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3531 IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Grand mal seizure DUE TO (c) Epilepsy		INTERVAL BETWEEN ONSET AND DEATH minutes minutes years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 10-23-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/26/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR OCT 27 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

1-13-50

1-13-50

Washington

Director of Columbia College

John W. Smith

Letter

Joseph A. Smith

NY 11

NOT 11 1950

1950

14356

CERTIFICATE OF DEATH

14361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurei Riverdale		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS Laurel, Maryland	
3. NAME OF DECEASED (Type or print) Pecor, Eugene		4. DATE OF DEATH 10 27 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		11. BIRTHPLACE (County & State, or foreign country) New Hampshire	
13. FATHER'S NAME Charles A. Pecor		14. MOTHER'S MAIDEN NAME Helen Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 262-44-0691	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (b) Generalized Arteriosclerosis - unknown (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 21, 1967 to Oct 27, 1967 that (I) (we) last saw the deceased alive on Oct 27, 1967, and that death occurred at 11:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. C. J. Houmann		22d. ADDRESS 4404 Queensbury Rd Riverdale, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-31-1967	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. - WASH. D.C.		25a. REC'D BY REGISTRAR DATE NOV 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1-28-52

1-28-52

MEMORANDUM FOR THE RECORD

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible text follows, appearing to be a memorandum body with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

[Illegible signature]

[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14355

CERTIFICATE OF DEATH

14360

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POMFRET, MARYLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH DAVIS PECK				4. DATE OF DEATH Month OCTOBER Day 27 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 10 OCTOBER 89		9. AGE (In years last birthday) yrs. 78	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) ELMIRA, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE L DAVIS				14. MOTHER'S MAIDEN NAME JULIA ROE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-48-1881		17. INFORMANT Address Gen. Dewitt Peck, Pomfret, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO POSSIBLE PULMONARY EMBOLUS OR MYOCARDIAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO INFARCTION (c)							INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3 PM
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 25 October , 19 67 , to 27 Oct , 19 67 , that he (we) last saw the deceased alive on 27 October 19 67 , and that death occurred at 9:25 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Allen D Ward</i>				P.M. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 27 Oct 67	
22c. PHYSICIAN'S NAME (Type) ALLEN D WARD, MD				22d. ADDRESS MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASH DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
Burial		10-31-67		Arlington Nat.		Arlington, Arlington, Va.	
24. FUNERAL DIRECTOR <i>The Hunt Funeral Home, Waldorf, Md.</i>				25a. REC'D BY REGISTRAR DATE NOV 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #10a Film #G394 11/6/67 ph

14358

CERTIFICATE OF DEATH

14363

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 4711 67th Avenue			
3. NAME OF DECEASED (Type or print) Everett Ruebink Peterson				4. DATE OF DEATH Month October Day 28 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1913	9. AGE (In years last birthday) yrs. 54	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equipment Operator		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Rockstar, Minnesota		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Alvin Peterson				14. MOTHER'S MAIDEN NAME Laura Schuman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-24-4449		17. INFORMANT Ruth A. Peterson Address Hyattsville, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH A Few Months Many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/5 , 19 65 to 10/28 , 19 67 , that (I) (we) last saw the deceased alive on 10/24 , 19 67 , and that death occurred at 10:34 A.M. from causes and on the date stated above.							
22a. SIGNATURE Frederick Henry Wilhelm				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/28/67	
22c. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M.D.				22d. ADDRESS 6319 Leander Road, Chevy Chase, Prince Georges, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 3, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
Item #9 Film "G39" 11/13/67 ph													
14359													
14364													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park d. STREET ADDRESS 4200 Van Buren Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John F Pillsbury						4. DATE OF DEATH Month Oct. Day 29 Year 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 April 1893		9. AGE (In years lost birthday) 74 7/31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME William P. Pillsbury						14. MOTHER'S MAIDEN NAME Catherine Orem							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 578-14-9241		17. INFORMANT Ethel Pillsbury-wife Same as #2							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive Lung Disease 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Chronic Infection of Lung (c) Bronchiectasis												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10-12 , 19 67 , to 10-29 , 19 67 that (I) (we) last saw the deceased alive on 10-28 , 19 67 , and that death occurred at 2.00 AM from causes and on the date stated above.													
22a. SIGNATURE C. Reitz						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10 29 67					
22c. PHYSICIAN'S NAME (Type) Aaron Deitz M.D.						22d. ADDRESS Prince Georges Plaza, Hyattsville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-1-1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland							
24. FUNERAL DIRECTOR Lee Funeral Home 300 4th St. NE Wash. DC						25a. REC'D BY REGISTRAR OCT 31 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]					

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item #2d Film "G393 10/16/67 ph & Item #11
CERTIFICATE OF DEATH

14362

(M)

14357

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE P.G. b. COUNTY P.G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, DC	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGES GENERAL HOSPITAL		d. STREET ADDRESS Old Silver Hill Road 3504 BRANCH AVE. S.E.	
3. NAME OF DECEASED (Type or print) DR. MATTHEW PERSION		4. DATE OF DEATH Month 10 Day 2 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 15, 1898
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTAL SURGEON		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WISCONSIN / Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MAURICE PERSION		14. MOTHER'S MAIDEN NAME BERTHA KRASNICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT WIFE MRS. DOROTHY PERSION		Address AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary artery disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) anxiety neurosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to 10-1 , 19 67 , that (I) (we) last saw the deceased alive on 9-28 , 19 67 , and that death occurred at 5:30 AM, from causes and on the date stated above.			
22a. SIGNATURE Bernard H. Ostrow		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Bernard H. Ostrow, M.D.		22d. ADDRESS 8107 Eastern Ave., Silver Spring, MD.	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	23b. DATE THEREOF 10-4-67	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) MIDWAUKEE, WISCONSIN
24. FUNERAL DIRECTOR B. Dannausky & Son 3501-14th St NW		25a. REC'D BY REGISTRAR OCT 3 1967 DATE	
25b. REGISTRAR'S SIGNATURE John J. Judge			

11003

INSTITUTE OF CLIMATE

11003

PRINCE GEORGE

CHEVERLY

WASHINGTON, DC

PRINCE GEORGE GENERAL HOSPITAL

3504 SPANISH AVENUE, S.E.

PENSION

DR. MATTHEW

MAR. 10, 1998 02

WHITE

USA

WISCONSIN

CENTRAL JUNCTION

SETHIA KASNIK

MARTICE PENSION

MRS. CYNTHIA PENSION AS ABOVE

W-11

YES

MILWAUKEE, WISCONSIN

10-07

REVIEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (H)
25M 1/67

14360		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14365	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale) c. LENGTH OF STAY IN 1b 2 yrs. 26 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1700 Vee Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Erie T. Price First Middle Last 4. DATE OF DEATH Oct. 20, 1967 Month Day Year			5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 11, 1907 9. AGE (In years last birthday) yrs. 60 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursery School 10b. KIND OF BUSINESS OR INDUSTRY Nursery School 11. BIRTHPLACE (County & State, or foreign country) Louisa County, Va. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Green 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. unknown 17. INFORMANT Person Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; rheumatoid arthritis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from # 9/24, 1965 , to 10/20, 1967 , that (I) (we) last saw the deceased alive on 10/20, 1967 , and that death occurred at 8:45 P.M. , from causes and on the date stated above. 22a. SIGNATURE Moë Weiss 22c. PHYSICIAN'S NAME (Type) Moë Weiss, M.D. 22b. DATE SIGNED Oct. 20, 1967 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) 10/26/67 23b. DATE THEREOF 10/26/67 23c. NAME OF CEMETERY OR CREMATORY Harmon Memorial Park Landau Md. 23d. LOCATION (City or Town) (County) (State)			24. FUNERAL DIRECTOR Johnson & Jewlin 4804 Ba. Ave. N.W. 25a. REC'D BY REGISTRAR OCT 26 1967 25b. REGISTRAR'S SIGNATURE Charles Judge		

1960

UNITED STATES

1960

Department of the Interior

Division of Reclamation

Water Resources Division

San Francisco Office

San Francisco, California

San Francisco, California

San Francisco, California

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 142

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14366

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro Marlboro d. STREET ADDRESS RFD Box 3764 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph Adrian Proctor		4. DATE OF DEATH Month 10 Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 April 1894
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. emp.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Prince Georges, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Sylvester Proctor		14. MOTHER'S MAIDEN NAME Mary Ann Proctor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary M. Proctor		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 10-26-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-31-67	
23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		23d. LOCATION (City or town) (County) (State) Clinton P. Geo. Md.	
24. FUNERAL DIRECTOR Martell Adams Aquasas, Md.		25a. REC'D BY REGISTRAR NOV 2 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1962

1962

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE
TO THE SECRETARY OF THE INTERIOR

STATE OF ALABAMA
COUNTY OF [illegible]
[illegible]

TO THE SECRETARY OF THE INTERIOR
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside d. STREET ADDRESS 4804 O Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Marian Middle L Last Ransom			4. DATE OF DEATH Month Oct. Day 5 Year 19 67						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8. 15. 1914		9. AGE (In years last birthday) 53 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY at home			11. BIRTHPLACE (County & State, or foreign country) D C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Harry D. Poole					14. MOTHER'S MAIDEN NAME Amelia Able				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. no		17. INFORMANT Address Clarence G. Ransom 4804.0 st S E				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage, massive 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of pons and cerebellum (c) Hypertensive heart disease								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) was hospitalized attended the deceased from 10-4-1967 to Oct. 5, 1967 , that (I) was last saw the deceased alive on Oct. 5, 1967 , and that death occurred at 5:30 PM from the causes and on the date stated above.									
22a. SIGNATURE Oliver B. Bond					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-6-67		
22c. PHYSICIAN'S NAME (Type) Oliver Bond, M. D.					22d. ADDRESS 6872 Riverdale Rd. Lanham, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10.9.67		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town or county) (State) Suitland. Maryland		
24. FUNERAL DIRECTOR LEE FUNERAL HOME 300 4th ST					ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 11 1967		
							25b. REGISTRAR'S SIGNATURE Charles Judge		

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1941

CERTIFICATE OF DEATH

14363

14368

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMP SPRINGS MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake Beach</u>	
c. LENGTH OF STAY IN 1b <u>8 days</u>		d. STREET ADDRESS <u>STAR R+I Box 668</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANDREWS AFB.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OLAF E. RASMUSSEN</u>		4. DATE OF DEATH Month <u>28</u> Day <u>Oct</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 Nov 1916</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO MECHANIC USAF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USAF</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BRONX, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>RASMUS RASMUSSEN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE WARNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1932-1966</u>		16. SOCIAL SECURITY NO. <u>111-10-8714</u>	
17. INFORMANT <u>Star R+I Box 668</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u> DUE TO (b) <u>Hepatic Insufficiency</u> DUE TO (c) <u>Chronic Hepatic Cirrhosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>20 Oct., 1967</u> to <u>27 Oct., 1967</u> that (I) (we) last saw the deceased alive on <u>27 Oct., 1967</u> , and that death occurred at <u>8:45 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Ira A. Gould</u> M.D.		22b. DATE SIGNED <u>28 Oct '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>IRA A. GOULD, MD</u>		22d. ADDRESS <u>MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASH DC 20331</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-1-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR <u>Hutchins Funeral Home Annapolis Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 10&21 Film 396
12-22-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14364

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14369

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 41 B Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lorraine Elvira Redden			4. DATE OF DEATH Month Day Year 10 23 19 67						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-22-20			
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress		11. BIRTHPLACE (State or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Oliver Thomas Redden				14. MOTHER'S MAIDEN NAME Mary Jane Davis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578-12-3026		17. INFORMANT Address Hazel Rd Mar Seat Pleasant Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431X Acute myocarditis and pericarditis DUE TO (b) Organism undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10/26/67		23c. NAME OF CEMETERY OR CREMATORY Savage Cemetery		23d. LOCATION (City or Town) (County) (State) Savage Md.			
24. FUNERAL DIRECTOR DeWitt Donaldson Laurel Md				25a. RECD BY REGISTRAR DATE OCT 30 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge			

1934

THE UNIVERSITY OF CHICAGO

1934

1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14365 Item 2 See birth cert. ans 14370											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS						d. STREET ADDRESS 284 River View Village				e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CASEY			First Middle Last MARIE REED			4. DATE OF DEATH Month Day Year OCTOBER 7 1967					
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 OCT 67		9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months Days Hours Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CURTIS LYNN REED						14. MOTHER'S MAIDEN NAME KATHLEEN JOYCE ESSICK (*) HEAD, MD.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. N/A		17. INFORMANT KATHLEEN J. REED-MOTHER, VILLIAGE, INDIAN (*)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory and Cardiac Arrest DUE TO 7735 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Distress Syndrome DUE TO (c) Prematurity										INTERVAL BETWEEN ONSET AND DEATH 30 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6 OCT , 19 67 to 7 OCT , 19 67 , that (I) (we) last saw the deceased alive on 7 OCT , 19 67 , and that death occurred at 5:21 PM , from causes and on the date stated above.											
22a. SIGNATURE Herrick J. Cohen						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 7 OCT 67		
22c. PHYSICIAN'S NAME (Type) HERRICK J. COHEN						22d. ADDRESS 4168 SUTLAND RD, SUTLAND, MD 20023					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 10/11/67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND, MARYLAND						25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

7-247378

358

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BW-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 -

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 5104 41st. Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Adelaide First Middle Last Adelaide Carinna Reeside		4. DATE OF DEATH Month Day Year 10 28 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 July 1882 9. AGE (In years last birthday) yrs. 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Anderson C Quisenberry		14. MOTHER'S MAIDEN NAME Corinna B Broomhall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT John B Reeside		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 10-30-67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 1, 1967	23c. NAME OF CEMETERY OR REPOSITORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Va.
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 1 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

14371

1957

1957

[Faint, mostly illegible text covering the main body of the page, possibly a letter or report.]

NOV 1 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE GEORGIA b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDEN			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS					d. STREET ADDRESS GENERAL DELIVERY					
3. NAME OF DECEASED (Type or print) First Middle Last ENOCH NMN REID, JR					4. DATE OF DEATH Month Day Year OCT 16 1967					
5. SEX MALE	6. COLOR OR RACE NEGROE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 FEB 1919		9. AGE (In years lost birthday) yrs. 48		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US ARMY			10b. KIND OF BUSINESS OR INDUSTRY US ARMY		11. BIRTHPLACE (County & State, or foreign country) ABBEVILLE, GEORGIA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ENOCH REID					14. MOTHER'S MAIDEN NAME NANCY FULLER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES			16. SOCIAL SECURITY NO. 258-12-6060		17. INFORMANT WIFE		Address SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 ARTERIOSCLEROTIC HEART DISEASE OTHER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DIABETES MELLITUS OTHER (c) CANCER OF LUNG WITH METASTASIS										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from 16 Oct, 1967, to 16 Oct, 1967 that (X) (we) lost saw the deceased alive on 16 Oct 67 19, and that death occurred at 9:45 AM, from causes and on the date stated above.										
22a. SIGNATURE <i>R. S. Nelson</i>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. AM			22b. DATE SIGNED 16 Oct 67		
22c. PHYSICIAN'S NAME (Type) ROBERT S. NELSON, CAPT, USAF MC					22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10/18/67		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Savannah, Ga.				
24. FUNERAL DIRECTOR Lowe's Funeral Home 1425 Md, Ave, N. E. Wash.D. C.					25a. REC'D BY REGISTRAR OCT 19 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div> <div>14368</div> <div>14373</div> </div> <div> <div>14368</div> <div>14373</div> </div>											
1. PLACE OF DEATH a. COUNTY Prince George's Co.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 19 1/2 mo.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hyattsville Nursing Home				d. STREET ADDRESS Springville Terrace 8805 Springville Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNIE				4. DATE OF DEATH Roth OCT. 17 1967				5. SEX F			
6. COLOR OR RACE W				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 6/16/1887			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. Worker				10b. KIND OF BUSINESS OR INDUSTRY WAR DEPT.				9. AGE (In years last birthday) 80			
11. BIRTHPLACE (County & State, or foreign country) Washington D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN A. ROTH			
14. MOTHER'S MAIDEN NAME MAGGIE HUBNER				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-36-1270			
17. INFORMANT ANNA MYERS-ALEX, VA.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4330 DUE TO (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) GENERALIZED ARTERIO SCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PNEUMONIA; HERPES ZOSTER				INTERVAL BETWEEN ONSET AND DEATH 1 MONTH YEARS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from month 9, 1966, to October 17, 1967, that (I) (we) last saw the deceased alive on October 16, 1967, and that death occurred at 9 1/2 M, from the causes and on the date stated above.			
22a. SIGNATURE Harold W. Draper				22b. DATE SIGNED 10/17/67				22c. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER M.D.			
22d. ADDRESS 911 SILVER SPRING AVE, SILVER SPRING, MD				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/20/1967			
23c. NAME OF CEMETERY OR CREMATORY Congregational				23d. LOCATION (City, town or county) (State) Washington, D.C.				24. FUNERAL DIRECTOR JAMES T. RYAN, INC. 317 PAVESIDE DR 3			
25a. REC'D BY REGISTRAR OCT 20 1967				25b. REGISTRAR'S SIGNATURE James T. Ryan				25c. DATE			

11943

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Saidman		4. DATE OF DEATH Month 10 Day 15 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Dec., 1899
9. AGE (In years birthday) yrs. 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Saidman		14. MOTHER'S MAIDEN NAME Pearl Stein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-14-1730	
17. INFORMANT Arnold Saidman		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) over 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>		22. DATE SIGNED 10-15-67	
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-17-67	23c. NAME OF CEMETERY OR CREMATORY National Memorial Park	23d. LOCATION (City or Town) (County) (State) Falls Church Va.
24. FUNERAL DIRECTOR Goldberg Funeral Home		25a. REC'D BY REGISTRAR OCT 20 1967	
ADDRESS 4217 9th St., N.W.		25b. REGISTRAR'S SIGNATURE Charles Judge	

1937

REVENUE DEPARTMENT

1937

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1937 OCT 20

CERTIFICATE OF DEATH

14375

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4419 WHITEHALL STREET			d. STREET ADDRESS 4419 WHITEHALL STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ALBERT FREDERICK SCHAUB			4. DATE OF DEATH Month OCTOBER Day 22 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH OCTOBER 23, 1884		9. AGE (In years last birthday) yrs. 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY U. S. GOVERNMENT		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D. C.	
13. FATHER'S NAME HERMAN SCHAUB			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address MELVIN E. SCHAUB 4411 WHITEHALL ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 332x Cerebral Thrombosis IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 hrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 7, 1946 , to Oct. 22, 1967 , that (I) (we) last saw the deceased alive on 10/21/67 , and that death occurred at 1237 M, from causes and on the date stated above.					
22a. SIGNATURE Frank S. Pellegrini			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/22/67
22c. PHYSICIAN'S NAME (Type) FRANK S. PELLEGRINI			22d. ADDRESS 3611 BRANCH AVE SE 20031		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/25/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND	
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME			25a. REC'D BY REGISTRAR DATE OCT 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge
4308 SUITLAND ROAD, SUITLAND, MARYLAND					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14371

CERTIFICATE OF DEATH

14376

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12903 Bowie Road Apt 101</u>		d. STREET ADDRESS <u>12903 Bowie Rd</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES EMMA SCHIMPF</u>		4. DATE OF DEATH <u>Oct 1</u> 1967	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1893</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>4</u> IF UNDER 24 HRS: Hours <u>7</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic companion</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Tazewell, Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hall</u>		14. MOTHER'S MAIDEN NAME <u>EMMA OSIER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-8889</u>	
17. INFORMANT <u>Wm J. Schimpf</u>		Address <u>12903 Bowie Rd Laurel Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> DUE TO <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Pulmonary Tuberculosis, arrested</u> DUE TO <u>2 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-18</u> , 19 <u>67</u> , to <u>10-1</u> , 1967, that (I) (we) last saw the deceased alive on <u>10-1</u> , 1967, and that death occurred at <u>2:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando V. Goco, M.D.</u>		22b. DATE SIGNED <u>10-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rolando V. Goco, M.D.</u>		22d. ADDRESS <u>704 Gorman Ave, Laurel, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH VA</u>
24. FUNERAL DIRECTOR <u>PEARSON FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 4 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11111

CERTIFICATE OF DEATH

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11111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14372

14377

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 2yrs. 78days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 5033 Call Place S.E.	
3. NAME OF DECEASED (Type or print) Loretta		4. DATE OF DEATH Month October Day 9 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/83
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min. 9 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Nassau, Bahama Island		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jerry Ricardo		14. MOTHER'S MAIDEN NAME Mary Bascade	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Decedent)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombo-embolism 331x DUE TO (b) Recurrent cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that it (this hospital) attended the deceased from 7-23 , 1965, to 10-9 , 1967, that we we last saw the deceased alive on 10-9 19 67 , and that death occurred 12:15PM , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 10-9-67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/13/67	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cem.	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Robert G. McGuire		25a. REC'D BY REGISTRAR OCT 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

1-1-57

STATE OF OHIO

1-1-57

D.C.

Prince George

Washington

1771-1800

Glenn Dale (Central)

3033 Call Place S.E.

Glenn Dale Hospital

October

Washington

London

1953

12/1/53

Female Negro

USA

Nassau, Bahamas Island

--

Barbados

Mary Annette

Larry Ricardo

(husband)

Unknown

no

Information received from

Glenn Dale Hospital, Washington

Glenn Dale Hospital, Washington

10-0

1-1-57

10-0

10-0

10-1-57

Glenn Dale Hospital
Glenn Dale, Maryland

Glenn Dale, M.D.

Glenn Dale, M.D.

Glenn Dale, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14373

14378

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale)		c. LENGTH OF STAY IN 1b 11 mo. 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 406 M. Street, N.W.	
3. NAME OF DECEASED (Type or print) Rebecca First Middle Last Seabrook		4. DATE OF DEATH Month Day Year Oct. 20 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 4, 1914
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Stokes		14. MOTHER'S MAIDEN NAME Rena ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Information from D.C. General Hospital		Address Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible pulmonary embolism (clinical) DUE TO (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH sudden unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral blindness due to optic atrophy; chronic brain syndrome		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 28, 19 66 , to Oct 20, 19 67 , that (I) (we) last saw the deceased alive on Oct 20, 19 67 , and that death occurred at 8:15 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED Oct. 20, 1967	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-28-67	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Frazier Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE OCT 25 1967	
ADDRESS 389 R.I. Ave. N.W.		25b. REGISTRAR'S SIGNATURE O. C. Jones	

1941

MINISTRY OF DEFENSE

SECRET

1. The purpose of this document is to provide information on the activities of the Ministry of Defense during the year 1941.

2. The Ministry of Defense has been working to improve the efficiency of its operations and to ensure that it is able to meet the needs of the country.

3. The Ministry of Defense has been working to improve the efficiency of its operations and to ensure that it is able to meet the needs of the country.

4. The Ministry of Defense has been working to improve the efficiency of its operations and to ensure that it is able to meet the needs of the country.

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19. The Ministry of Defense has been working to improve the efficiency of its operations and to ensure that it is able to meet the needs of the country.

20. The Ministry of Defense has been working to improve the efficiency of its operations and to ensure that it is able to meet the needs of the country.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14379

14374

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 10-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 6815 Riverdale Road	
3. NAME OF DECEASED (Type or print) Hazel A. Sechez		4. DATE OF DEATH Month 10 Day 29 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-24-27
9. AGE (In years last birthday) yrs. 40		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales woman	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Forrest Baker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital records		Address Cheverly Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 976X IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:00am 10-22- 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) same as #2		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-30-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 31, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR G. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR NOV 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14375 Item #15 Film #G394 11/13/67 ph												14380			
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham Md.				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md. 16-1									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Magnolia Gardens Nursing Home						d. STREET ADDRESS 5400 54th avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Franz J			Middle J			Last Seiders			4. DATE OF DEATH Month Oct Day 10 Year 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 19, 1904			9. AGE (In years lost birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired electrician				10b. KIND OF BUSINESS OR INDUSTRY U S Government				11. BIRTHPLACE (County & State, or foreign country) Maine				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Harold L Seiders						14. MOTHER'S MAIDEN NAME Elizabeth Lane									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes no U.S. Navy 5/12/19 to 9/2/21				16. SOCIAL SECURITY NO 19 to 9/2/21				17. INFORMANT Rose I Seiders				Address East Riverdale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1621 Medialytic Ca of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Bronchogenic Ca of Left Bronchus 6 months DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 3, 1967, to 10-10, 1967, that (I) (we) last saw the deceased alive on 10-10, 1967, and that death occurred at 3:30 P.M. from causes and on the date stated above.															
22a. SIGNATURE George Hageage						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-11-67							
22c. PHYSICIAN'S NAME (Type) George Hageage						22d. ADDRESS Cottage City, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Suitland Pro Georges Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

1884

OFFICE OF THE SECRETARY

1884

Private Secretary
to the Secretary
of the Army
Washington, D.C.
April 10, 1884
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 4th inst. in relation to the proposed purchase of land for the establishment of a military reservation at the mouth of the River, and in reply to inform you that the same has been referred to the proper authorities for their consideration.

Very respectfully,
Your obedient servant,
John A. B. Smith
Secretary of the Army

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>T.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>		d. STREET ADDRESS <u>1704 Regaton Road</u>	
3. NAME OF DECEASED (Type or print) <u>RICHARD EDWARD SEMERJIAN</u>		4. DATE OF DEATH <u>OCTOBER 23, 1967</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1913</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>		12. KIND OF BUSINESS OR INDUSTRY <u>C.E.CO</u>	
13. FATHER'S NAME <u>Ralph Semerjian</u>		14. MOTHER'S MARRIED NAME <u>Ethel Boyan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marvin Semerjian</u>		18. ADDRESS <u>Same as #2</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c) <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 m med</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19 67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1963</u> to <u>Oct 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>9/28, 1967</u> , and that death occurred at <u>10:13 PM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>Mar Schneider</u>	
22b. DATE SIGNED <u>10/24/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Marvin Schneider, M.D.</u>	
22d. ADDRESS <u>911 Silver Spring Avenue, S.S., MD.</u>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/27/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>H. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Charles Manor Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. RECEIVED BY REGISTRAR <u>OCT 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Manor Md.</u>		25c. ADDRESS <u>254 Carroll St. N.W.</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

VR A15 (4)
2DM 1/65

10-1

THE STATE OF TEXAS

10-1



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14382

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT HEIGHTS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUITLAND NURSING HOME		d. STREET ADDRESS 7915 FOSTER STREET	
3. NAME OF DECEASED (Type or print) EVELYN K. SERCOMBE		4. DATE OF DEATH Month 10 - Day 7 - Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1879
9. AGE (In years last birthday) yrs. 88		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARTIN TRESIDDER		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT FRED W. TRESIDDER SAME AS # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Explosion - Arteriovenous Aneurysm DUE TO Chloroform Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 8-9 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/15/59 to 10/7/67 , that (I) (we) last saw the deceased alive on 10/6/67 19__, and that death occurred at 6:00 AM , from causes on and the date stated above.			
22a. SIGNATURE William C. Lambert		22b. DATE SIGNED 10/7/67	
22c. PHYSICIAN'S NAME (Type) WILLIAM C. LAMBERT		22d. ADDRESS 2932 - W ST., S.E. D.C. 20	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/10/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY	23d. LOCATION (City or Town) (County) (State) UPPER DARBY, PENNSYLVANIA
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR DATE OCT 9 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14378

CERTIFICATE OF DEATH

14383

1. PLACE OF DEATH a. COUNTY Pringe Geo. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier c. LENGTH OF STAY IN 1b 12 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3202 - Perry St.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3202 - Perry St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wharton B. Shackelford First Middle Last		4. DATE OF DEATH Oct. 9 1967 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/1889 9. AGE (In years last birthday) yrs. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (County & State, or foreign country) Virginia
13. FATHER'S NAME Albert Shackelford		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17. INFORMANT Mrs. Mabel H. Shackelford (above) Address (Wife) address	
16. SOCIAL SECURITY NO. 578-01-2143A		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Heart. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Hypertensive Arterio-sclerotic Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 36 Hrs. 10 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 1957 to 10/9, 1967 , that (I) (we) last saw the deceased alive on 10/9 1967 , and that death occurred at 11:45 M, from causes and on the date stated above.			
22a. SIGNATURE Charles C. Hageage 22c. PHYSICIAN'S NAME (Type) Charles C. Hageage, M.D.		22b. DATE SIGNED Oct 13 1967 22d. ADDRESS 3308 Perry St. Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR OCT 13 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Miss.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Davis Sharp		4. DATE OF DEATH Month 10 Day 22 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Feb., 1945
9. AGE (In years lost birthday) 22 yrs.		10. IF UNDER 1 YEAR Months 22 Days 19 Hours 67 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cadet		11b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Academy	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lawler D. Sharp	
14. MOTHER'S MAIDEN NAME Elizabeth Busby		15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) yes At time of Death 428-88-5528	
16. SOCIAL SECURITY NO. US Naval Hospital, Bethesda, Md.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO (b) Trauma-auto accident DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which collided with a sign.	
20c. TIME OF INJURY Month, Day, Year 2:40 a.m. 10 22 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work Rt 450 nr Central Ave., P.G. Md.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 10-22-67	
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10/24/67	
23c. NAME OF CEMETERY OR CREMATORY Hattiesburg, Mississippi		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Falls Church Funeral Home, Falls Church, Va.		25a. REC'D BY REGISTRAR OCT 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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14380

CERTIFICATE OF DEATH

14385

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN lb 4 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.		d. STREET ADDRESS 5700 Queens Chapel Road	
3. NAME OF DECEASED (Type or print) First Emma Middle P. Last Sheehy		4. DATE OF DEATH Month October Day 28 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1873
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Archibald Hutton		14. MOTHER'S MAIDEN NAME Ella Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-52-9266	
17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Generalized arteriosclerosis with DUE TO (c) renal failure			INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1956 , to 10-28 , 1967, that (I) (we) lost saw the deceased alive on 10-27 , 1967, and that death occurred at 2 A M, from causes and on the date stated above.			
22a. SIGNATURE Ronald S. Fleischer M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10-28-67
22c. PHYSICIAN'S NAME (Type) RONALD S. FLEISCHER		22d. ADDRESS 7411 RIGGS Rd, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR ADDRESS F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 31 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1951

1951

DATE OF DEATH: 1951

PLACE OF DEATH: 1951

NAME OF DECEASED: 1951

AGE: 1951

SEX: 1951

CAUSE OF DEATH: 1951

DATE OF BURIAL: 1951

PLACE OF BURIAL: 1951

NAME OF FUNERAL HOME: 1951

NAME OF MINISTER: 1951

NAME OF CHURCH: 1951

NAME OF CEMETERY: 1951

NAME OF INTERVIEWER: 1951

NAME OF WITNESS: 1951

NAME OF SIGNER: 1951

NAME OF SIGNER: 1951

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TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND

CERTIFICATE OF DEATH

Reg. Dist. No.

14381

14386

1. PLACE OF DEATH a. COUNTY Prince George's County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY P.G. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's Hospital		d. STREET ADDRESS 7600-Fontain Blu Carrolton Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Neda (Ferneda) First Middle Last Shortt		4. DATE OF DEATH Month Day Year Oct. 6 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-03
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Childus		14. MOTHER'S MAIDEN NAME Martha Puritt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 279 24 4211	
17. INFORMANT Harold Shortt-son		Address Hyatts, Md. 3617 Gallatin St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 5, 1967, to Oct. 6, 1967, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4637 EASTERN AVE., WASH., D.C. 20018			
ACTUAL SIGNATURE Samuel J. N. Sugar		M.D.	
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR, M.D.		Oct. 6, 1967	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-67	
22c. NAME OF CEMETERY OR CREMATORY Woodside Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		ADDRESS 300-4th St. N.E. Wash., D.C.	
24a. REC'D BY REGISTRAR OCT 19 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

STATE DEPARTMENT

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clinton		c. LENGTH OF STAY IN 1b Driving Thru		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Rt. 5, nr Surrats Rd.		d. STREET ADDRESS 401 11 th St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cheryll Lee Smalls		4. DATE OF DEATH Month 10 Day 14 Year 1967			
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Dec., 1958	9. AGE (In years last birthday) 8 yrs.	IF UNDER 1 YEAR Months 14 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Rev. Albert O. Smalls		14. MOTHER'S MAIDEN NAME Mrs. Mattie Hicks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Albert D. Smalls - 401 11th Street, S. E.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8164 Burns- 100% of body surface IMMEDIATE CAUSE (a) 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Passenger of car involved in collision.					INTERVAL BETWEEN ONSET AND DEATH Minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger of car involved in collision.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8:20 pm Month 8 Day 14 Year 1967		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. Rt. 5 Clinton	
20f. (City or town) P.G. Md.		20g. (County) (State) P.G. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale		22. DATE SIGNED 10-15-67		22. DATE SIGNED 10-15-67	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		23a. BURIAL, CREMATION, REMOVAL (Specify) 10-19-67		23b. DATE THEREOF 10-19-67	
23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL CEMETERY		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND		23e. REC'D BY REGISTRAR 1967	
24. FUNERAL DIRECTOR JOHN T. RHINES FUNERAL HOME, WASHINGTON, D. C.		24a. REC'D BY REGISTRAR 1967		24b. REGISTRAR'S SIGNATURE John T. Rhines	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14383 CERTIFICATE OF DEATH 14388											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT HEIGHTS c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7206 ELMHURST STREET						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND f. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT HEIGHTS d. STREET ADDRESS 7206 ELMHURST STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Paul Oster Smeltzer First Middle Last						4. DATE OF DEATH Month Day Year 10 24 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 13, 1915		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days 15 mo.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY D.C. GOVERNMENT		11. BIRTHPLACE (County & State, or foreign country) PENNA.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HERBERT SMELTZER						14. MOTHER'S MAIDEN NAME NELLIE OSTER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. PHYLLIS B. SMELTZER		17. INFORMANT SAME AS # 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Coronary Artery Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 15 mo.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While Not While et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) 10/23		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/1 , 19 67 to 10/23 , 19 67 , that (I) (we) last saw the deceased alive on 10/23 , 19 67 , and that death occurred at 2A M, from the causes and on the date stated above.											
22a. SIGNATURE Frank J. Talbot M.D.						22b. DATE SIGNED 10/24/67					
22c. PHYSICIAN'S NAME (Type) Frank J. Talbot MD						22d. ADDRESS 4273 Branch Ave Marlow Heights MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10/27/67		23c. NAME OF CEMETERY OR CREMATORY OSTERBURG REFORMED CEMETERY OSTERBURG, PENNA.				23d. LOCATION (City, town or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND						25a. REC'D BY REGISTRAR OCT 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

14384

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14389

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVER DALE, MD</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospital</u>				d. STREET ADDRESS <u>1600 Washington Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Smith</u> Middle <u>Harry</u> Last <u>J.</u>				4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1885</u>		9. AGE (In years lost birthday) <u>82 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAYOR APT.'S</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>577-22-0856</u>		17. INFORMANT <u>Smith, David</u> Address <u>Laurel, Md</u> <u>1600 Washington Blvd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> 464X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE THROMBOPHLEBITIS</u> (c) <u>2 WKS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>67</u> , to <u>27 OCT</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>27 OCT</u> 19 <u>67</u> , and that death occurred at <u>1040 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>C. J. Houmann</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>				22d. ADDRESS <u>RIVERDALE MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-31-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wash. Nat. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Md</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers</u>				ADDRESS <u>Riverdale Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 1 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

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CERTIFICATE OF DEATH

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5409 Riverdale Road	
3. NAME OF DECEASED (Type or print) First Middle Last Henry Howard Smith		4. DATE OF DEATH Month Day Year Oct 13, 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-09
9. AGE (In years lost birthday) yrs. 58		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical contractor		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Oliver C. Smith		14. MOTHER'S MAIDEN NAME Hazel C Parrish	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 880 03 0182	
17. INFORMANT Catherone H Smith		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5810 liver failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Cirrhosis of liver (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kenoe M.D., Riverdale, Maryland		22. DATE SIGNED 10-14-67	
EXAMINER'S NAME (Type) John Kenoe M.D., Riverdale, Maryland		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE THEREOF Oct 16, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14386
14391
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hyattsville Nursing Home		d. STREET ADDRESS 1513 Jonathon St.	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian K. SMITH		4. DATE OF DEATH Month Day Year Oct. 12 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/86
9. AGE (In years last birthday) 80 yrs.		10. IF UNOER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady-Lansburgh's Dept. Store		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Smith		14. MOTHER'S MAIDEN NAME Lena Rechweig	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-01-6973	
17. INFORMANT Andrew H. Smith-		Address 1515 Jonathon St. Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, breast with 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) generalized metastases. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 22, 1966, to Oct 12, 1967, that (I) (we) last saw the deceased alive on Oct 10 1967, and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE William F. Simpson, M.D.		22b. DATE SIGNED 10/12/67.	
22c. PHYSICIAN'S NAME (Type) William F. Simpson, M.D.		22d. ADDRESS 6216 N.H. Ave NE.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10/14/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR OCT 13 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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14392

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr^o Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8Hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Goergoe General Hospital		d. STREET ADDRESS 7608 Foutianblue Dr.,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Robert Daniel Smith		4. DATE OF DEATH Month Oct Day 28 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 14, 1915
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Tobacco co	11. BIRTHPLACE (County & State, or foreign country) Wicomico County Md
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Walter L Smith	
14. MOTHER'S MAIDEN NAME Mattie Parsons		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W W II	
16. SOCIAL SECURITY NO. 214 10 9013		17. INFORMANT Address Mrs Mattie Smith Pittsville Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-28-1967 to 10-28-1967 that (I) (we) last saw the deceased alive on 10-28-1967 and that death occurred at 5:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE John H. Kenge		22b. DATE SIGNED 10-28-67	22c. PHYSICIAN'S NAME (Type) JOHN H. KENG
22d. ADDRESS 6300 Riverdale Rd.		22e. ADDRESS Reverend	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-31-1967	23c. NAME OF CEMETERY OR CREMATORY Grave Cemetery	23d. LOCATION (City or Town) (County) (State) Pittsville, Maryland
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE OCT 31 1967	25b. REGISTRAR'S SIGNATURE Charles J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Charles Jones John A. Rhines M.D. By Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14388 CERTIFICATE OF DEATH 14393									
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glenarden Md.</u> c. LENGTH OF STAY IN 1b <u>11 Sept 1967</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7912 Echols</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>WASH.</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47-3</u> d. STREET ADDRESS <u>1440 W 5th N.W Apt 18</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Wilbert James Smith</u>			4. DATE OF DEATH <u>Oct 16 1967</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 18, 1900</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDENING</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Sampson County N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>MATTHEW JAMES SMITH</u>					14. MOTHER'S MAIDEN NAME <u>MARY MARIE DIXON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>578-14-1691</u>		17. INFORMANT <u>Miss Gertrude B. Smith</u>			Address <u>7912 Echols Glenarden Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Heart disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10 YEARS</u> <u>54 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>15 Oct</u> , 19 <u>67</u> , to <u>16 Oct</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>15 Oct</u> 19 <u>67</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>16 Oct 67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Ronald P. Hainston</u>					22d. ADDRESS <u>3302 Hayes Glenarden Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10-20-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Cty, Md.</u>		
24. FUNERAL DIRECTOR <u>John T. Rhines Co Funeral Home</u>					ADDRESS <u>3015 N.E. 12th St.,</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
					DATE <u>OCT 19 1967</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB		c. LENGTH OF STAY IN 1b 3 Mos 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 7100 ORIOLE AVENUE	
3. NAME OF DECEASED (Type or print) LUEBERTHA JANNETTE SONNENBURG		4. DATE OF DEATH OCTOBER 2 1967	
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 19 NOV 1910
9. AGE (In years, last birthday) 57 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE	
11. BIRTHPLACE (County & State, or foreign country) FT SCOTT, KANSAS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES W. BROWN		14. MOTHER'S MAIDEN NAME BERTHA D. HULSERUS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. 321-34-2221	
17. INFORMANT HUSBAND		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750 CARCINOMATOSIS FROM OVARY DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 15 Jul, 1967, to 2 Oct, 1967 that (he) (we) last saw the deceased alive on 2 Oct, 1967, and that death occurred at 5:45 AM, from causes and on the date stated above.			
22a. SIGNATURE Robert E. Harris		22b. DATE SIGNED 2 Oct 67	
22c. PHYSICIAN'S NAME (Type) ROBERT E. HARRIS, CAPTUSAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/7/1967	23c. NAME OF CEMETERY OR CREMATORY National Memorial Park	23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia
24. FUNERAL DIRECTOR Ives Funeral Home		25a. REC'D BY REGISTRAR OCT 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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DEATH OF DEATH

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Items #8 & 9 Film #G394 10/27/67 ph

CERTIFICATE OF DEATH

14395

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4088xx36txxxstxxxx Mt. Rainier 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 4025 36th Street	
3. NAME OF DECEASED (Type or print) First George Middle W Last Speckman		4. DATE OF DEATH Month Oct., Day 15 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888 6 July 1988
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM F. SPECKMANN		14. MOTHER'S MAIDEN NAME MARIE B. LEDERER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ***** 217-30-2456	
17. INFORMANT BERNICE M. SPECKMAN WIFE		Address SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug, 1967, to Oct 15, 1967 that (I) (we) last saw the deceased alive on Oct 14 1967, and that death occurred at 5:30 AM, from causes and on the date stated above.			
22a. SIGNATURE Don Bloumen M.D.		22b. DATE SIGNED Oct 15, 1967	
22c. PHYSICIAN'S NAME (Type) DON B. CAMERON		22d. ADDRESS 3503 PERRY ST MT RAINIER MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10-18-67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland
24. FUNERAL DIRECTOR GASCH'S		25. REC'D BY REGISTRAR OCT 19 1967	
HYATTSVILLE, MARYLAND		25b. REGISTRAR'S SIGNATURE R. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Medical examiner notified and approved

Dr John Kehoe
Pro George's County Md.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5712 - 66th. Ave., Riverdale, Maryland		d. STREET ADDRESS 5712 - 66th. Ave.	
3. NAME OF DECEASED (Type or print) William Thomas Speer		4. DATE OF DEATH Month October Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 6, 1928
9. AGE (In years last birthday) 39 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney	11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Thomas Speer Sr.	
14. MOTHER'S MAIDEN NAME Elsie Klinehause		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Josephine Speer - Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas 1992 and Adenocarcinoma of colon (two separate malignancies) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 23 March , 19 67 to 8 October , 19 67 , that (I) (we) last saw the deceased alive on 19 August , 19 67 , and that death occurred at 3:20 p.m. , from causes and on the date stated above.			
22a. SIGNATURE <i>Richard Compton</i>		22b. DATE SIGNED 9 October 67	
22c. PHYSICIAN'S NAME (Type) J. Richard Compton, M.D.		22d. ADDRESS 612 Main Street, Laurel, Md 20810	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 11, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR OCT 11 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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U. S. DEPARTMENT OF COMMERCE

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro		c. LENGTH OF STAY IN b 4-yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD Box 2575-Brown Station Road				d. STREET ADDRESS RFD Box 2575-Brown Sta.Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Mary Squibb				4. DATE OF DEATH Month Day Year October 19, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1902		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Franklin Fernwald				14. MOTHER'S MAIDEN NAME Matilda (nee Kreitz)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Warren S. Squibb-Same as Item #2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 days 3 yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1940 to Oct. 19, 1967 , that (I) () last saw the deceased alive on Oct. 19, 1967 , and that death occurred at 11:30 PM from the causes and on the date stated above.							
22a. SIGNATURE William J. P. Howard, M.D.				22b. DATE SIGNED 10/19/67		22c. PHYSICIAN'S NAME (Type) William J. P. Howard, M.D.	
22d. ADDRESS 1331 Staples St. NE Wash. D.C.		22e. REC'D BY REGISTRAR OCT 30 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/24/67		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Protestant Union Township, Episcopal Cemetery		23d. LOCATION (City, town or county) (State) Berks County, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro				25a. REC'D BY REGISTRAR OCT 30 1967			

1957
STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

George Francis
Mary Harbor - Upper Harbor
New York

Box 2275-Brown Station Road
Mary Harbor - Upper Harbor
New York

October 17, 1957
Mary Harbor - Upper Harbor
New York

White
Mary Harbor - Upper Harbor
New York

Home
Mary Harbor - Upper Harbor
New York

Franklin Townsend
Mary Harbor - Upper Harbor
New York

Mary Harbor - Upper Harbor
New York

George Francis
Mary Harbor - Upper Harbor
New York

George Francis
Mary Harbor - Upper Harbor
New York

George Francis
Mary Harbor - Upper Harbor
New York

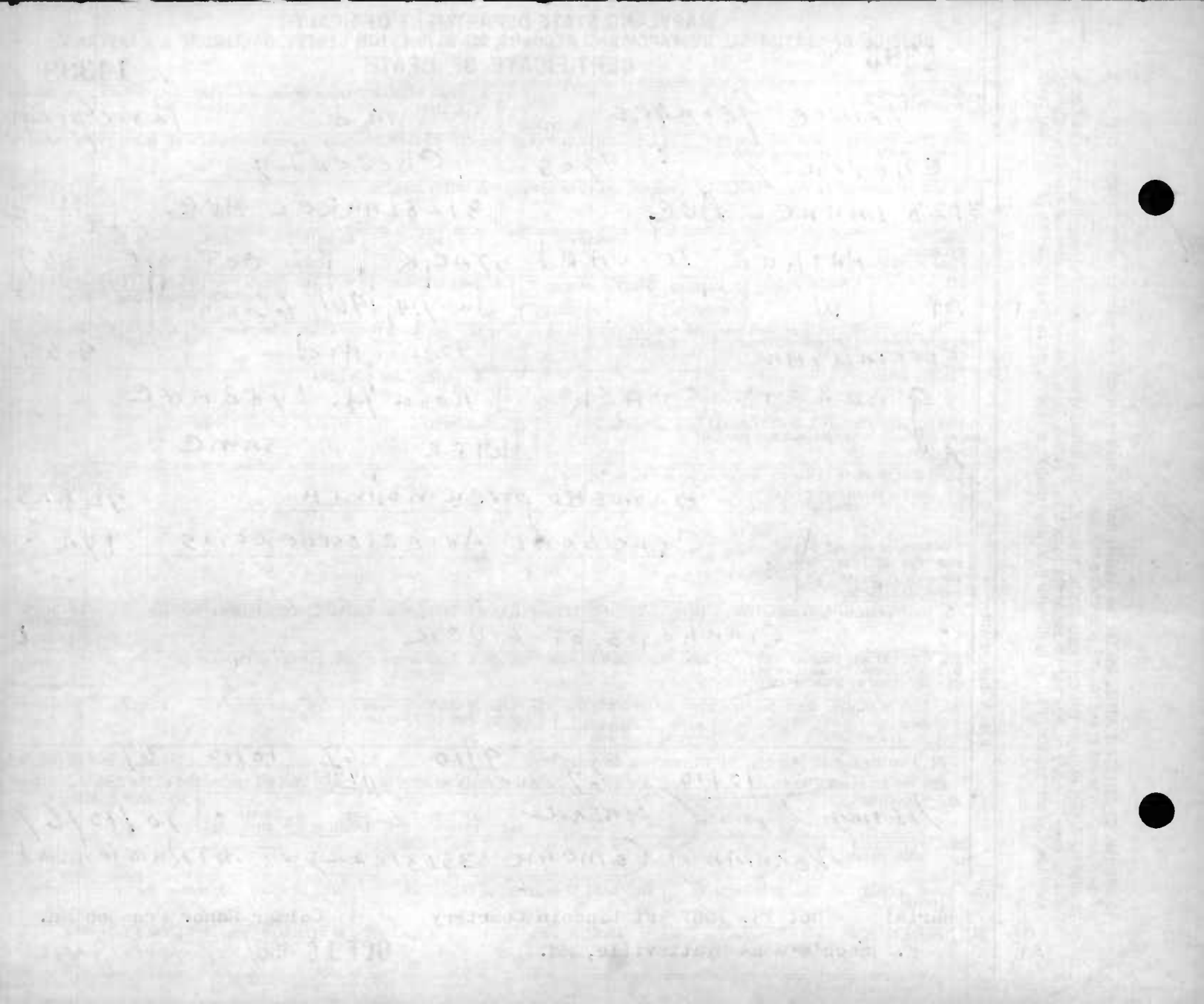
George Francis
Mary Harbor - Upper Harbor
New York

George Francis
Mary Harbor - Upper Harbor
New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
14398																			
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>														
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>					c. LENGTH OF STAY IN 1b <u>4 yrs.</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> 16-1									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3128 LAUREL AVE.</u>					d. STREET ADDRESS <u>3128 LAUREL AVE</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>ARTHUR LEONARD STACK</u>					4. DATE OF DEATH <u>OCT 10 1967</u>					Month Day Year									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 14, 1901</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <u>BALT. MD</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>GARNETT STACK</u>					14. MOTHER'S MAIDEN NAME <u>ROSA A. LYDDANE</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>					16. SOCIAL SECURITY NO.					17. INFORMANT <u>WIFE</u>					Address <u>SAME</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIO SCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CIRRHOSIS OF LIVER</u>										INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>1 yr.</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> , 19 <u>67</u> to <u>10/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/10</u> , 19 <u>67</u> , and that death occurred at <u>11:25 PM</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>Norman J. Comeau</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <u>10/10/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>NORMAN J. COMEAU</u>					22d. ADDRESS <u>3503 PEARLY ST MT RAINIER MD</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>Oct 14, 1967</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Colmar Manor Pro Geo Md.</u>				
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>					ADDRESS					25a. REC'D BY REGISTRAR <u>OCT 16 1967</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

MA67-13
14394

14399

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ranier			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 2701 Webster St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edmund Middle A Last Stahl				4. DATE OF DEATH Month October Day 8 Year 1967			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/22	9. AGE (In years lost birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Supply		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Stahl, Aalexander				14. MOTHER'S MAIDEN NAME Ronnberg, Ann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 104-01-2968		17. INFORMANT Hospital Record Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hepatic failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe fatty change of liver DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 week 3-6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure, anemia, alcoholism							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE , 1967 to 8 OCT , 1967, that (I) (we) last saw the deceased alive on 8 OCT. 1967, and that death occurred at 9:15M , from causes and on the date stated above.							
22a. SIGNATURE C. J. HOUmann				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-8-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN				22d. ADDRESS RIVERDALE MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/10/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Home Inc.				25a. REC'D BY REGISTRAR DATE OCT 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1-13-59

1-13-59

George George

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14400

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,		c. LENGTH OF STAY IN tb 23 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D C		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 3009 Douglas Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Stubbs, Harry E		4. DATE OF DEATH Month October Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/97
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY WSSC	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stubbs, Prince		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Admitting Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PERFORATION OF ANASTOMOSIS (GASTRIC RESECTION) DUE TO (c) CARCINOMA OF STOMACH		INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 10/8 19 67 , and that death occurred at 7:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) [Signature]		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR [Signature]		25a. REC'D BY REGISTRAR [Signature]	
25b. REGISTRAR'S SIGNATURE [Signature]		DATE OCT 11 1967	

1-1-1950

DATE OF DEATH

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items #13 & 14 Film #G393 10/16/67 ph									
14396									
14401									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham, Md.			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.			16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Magnolia Gardens Nursing Home					d. STREET ADDRESS 5303 41th Place			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emily J. Suess					4. DATE OF DEATH Month Day Year October 8, 1967				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1890		9. AGE (In years last birthday) yrs. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME William F. Jacobs / Jacobi					14. MOTHER'S MAIDEN NAME Maud Alice Moore Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Address Anthony W Suess Hyattsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypertensive Acute Disease DUE TO (c) Arteriosclerotic Heart Disease								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 8, 1967 , to Oct 7, 1967 , that (I) (we) last saw the deceased alive on 106 1967 , and that death occurred at 106 M, from causes and on the date stated above.									
22a. SIGNATURE C. Deitz					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-9-67		
22c. PHYSICIAN'S NAME (Type) A Deitz					22d. ADDRESS Pro Geo Plaza Hyattsville, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR DATE OCT 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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STATE OF TEXAS

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2c & d Film #G393 10/17/67 ph

14397

CERTIFICATE OF DEATH

14402

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) p. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville// Mt. Rainier	
c. LENGTH OF STAY IN TB 9 days		d. STREET ADDRESS 4227 29th Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Patrick J. Swift		4. DATE OF DEATH Month Day Year Oct. 6, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/75
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bricklayer	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Swift		14. MOTHER'S MAIDEN NAME Mary McHale	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-18-0424	
17. INFORMANT A		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, Left middle DUE TO Cerebral artery CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERALIZED (c) 1 YEAR			INTERVAL BETWEEN ONSET AND DEATH 9 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHO PNEUMONIA, BOTH LUNGS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 1, 1966 , to OCT 6, 1967 , that (I) (we) last saw the deceased alive on OCT 6, 1967 , and that death occurred at 12:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Samuel J. Sugar M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED OCT 6 '67
22c. PHYSICIAN'S NAME (Type) Smauel J.N. Sugar, M.D.		22d. ADDRESS 4637 Eastern Ave., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/10/67	23c. NAME OF CEMETERY OR CREMATORY St. Patrick Cemetery	23d. LOCATION (City or town) (County) (State) Blakely, Penna.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland	25a. REC'D BY REGISTRAR OCT 11 1967 DATE
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14398 CERTIFICATE OF DEATH 14403									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS 5808 Rittenhouse St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edgar F Talley					4. DATE OF DEATH Month Day Year Oct. 14 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 Aug., 1906		9. AGE (In years lost birthday) yrs. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Policeman		11. BIRTHPLACE (County & State, or foreign country) Belgrade Missouri			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob M. Talley					14. MOTHER'S MAIDEN NAME Ellen Hays				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II			16. SOCIAL SECURITY NO. 510-14-6415		17. INFORMANT Anne P. Talley Same as # 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 4200 <input checked="" type="checkbox"/> (b) Anterior wall Heart Disease. DO TO <input checked="" type="checkbox"/> (a) Cardiac Arrest. DO TO <input checked="" type="checkbox"/> (c) Congestive Heart Failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-9th, 1967, to 10-14th, 1967, that (I) (we) last saw the deceased alive on 10-14th, 1967, and that death occurred at 8:30 PM from causes and on the date stated above.									
22a. SIGNATURE Hernandez, MD					22b. DATE SIGNED 10/15/1967				
22c. PHYSICIAN'S NAME (Type) P. J. Hernandez, MD					22d. ADDRESS Prince Geo. Gen. Hosp.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-18-1967		23c. NAME OF CEMETERY OR CREMATORY National			23d. LOCATION (City or Town) (County) (State) Gulpepper, Va	
24. FUNERAL DIRECTOR Matthewly 131-11th St. S.E. D.C.					25a. REC'D BY REGISTRAR DATE OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14390

CERTIFICATE OF DEATH

14404

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MALCOLM GROW USAF HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL d. STREET ADDRESS 1409 SOUTHERN AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SHAW EDWARD TATE				4. DATE OF DEATH Month Day Year OCTOBER 20 1967			
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Oct 67		9. AGE (In years last birthday) yrs. 9	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGES, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT TERRILL TATE				14. MOTHER'S MAIDEN NAME ALVA JEAN JOHNSTON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. NA		17. INFORMANT MOTHER Address SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 3403 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) MENINGITIS & SEPSIS DUE TO (c) MULTIPLE CARDIAC ARRYTHMIAS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 14 hrs 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CONGENITAL SUPRA-VENTRICULAR TACHYCARDIA, ATRIAL FLUTTER						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE					
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12 Oct, 1967 to 20 Oct, 1967 , that (I) (we) last saw the deceased alive on 20 Oct 1967 , and that death occurred at 3:35 AM , from causes and on the date stated above.							
22a. SIGNATURE Richard W. Dodds M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 20 Oct 67	
22c. PHYSICIAN'S NAME (Type) RICHARD W. DODDS, CAPT, USAF, MC				22d. ADDRESS Malcolm Grow USAF Hospital Andrews AFB, Wash DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/23/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Gillian Cemetery		23d. LOCATION (City or Town) (County) (State) Eclectic, Alabama			
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				25a. REC'D BY REGISTRAR OCT 25 1967 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

Expenditure

2015/01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 2 hr. 55 min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 5124 Mangum Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virginia First Middle Last Tatman Flippo Tatman		4. DATE OF DEATH Month Day Year October 25 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1903
9. AGE (In years lost birthday) yrs. 64		IF UNDER 1 YEAR Months Days Hours Min. 16-1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nutritionist (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Dept. Agriculture	
11. BIRTHPLACE (County & State, or foreign country) Millboro, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Flippo E. R.		14. MOTHER'S MAIDEN NAME Laura Bell Bratton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 1		16. SOCIAL SECURITY NO. 215 26 2920	
17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Left Hemiplegia DUE TO (c) General arteriosclerosis 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1944 , 19 to Oct 25 , 19 67 , that (I) (we) last saw the deceased alive on Oct 25 , 19 67 , and that death occurred at 5:45 M, from causes and on the date stated above.			
22a. SIGNATURE L.W. Malin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L.W. MALIN M.D.		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR OCT 30 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14401									
14406									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE			c. LENGTH OF STAY IN lb 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLS CHURCH			83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS					d. STREET ADDRESS 3401 FIDDLERS GREEN			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last TAYLOR					4. DATE OF DEATH Month OCTOBER Day 3 Year 19 67				
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 APRIL 1922		9. AGE (In years lost birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) PUYALLUP, WASH.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WILLIAM BENTHIEN					14. MOTHER'S MAIDEN NAME LILLIAN BREFFIT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes give war or dates of service) NA		17. INFORMANT HUSBAND		Address SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5272 IMMEDIATE CAUSE (a) Acute Respiratory Insufficiency DUE TO Chronic Obstructive Pulmonary (b) Disease. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from 7 Sept, 1967 to 3 Oct, 1967, that (2) (we) last saw the deceased alive on 30 Oct 19 67, and that death occurred at 7:23 AM from causes and on the date stated above.									
22a. SIGNATURE John F. Lindeman					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3 Oct 67		
22c. PHYSICIAN'S NAME (Type) JOHN F. LINDEMAN, CAPT, USAF, MC					22d. ADDRESS Andrews AFB, Wash DC 20331 USAF Hospital Andrews				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-9-67		23c. NAME OF CEMETERY OR CREMATORY Old Takoma Cemetery		23d. LOCATION (City or Town) (County) (State) Takoma Wash.			
24. FUNERAL DIRECTOR Murphy Funeral Home Arlington, Va					25a. REC'D BY REGISTRAR OCT 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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CERTIFICATE OF DEATH

14402

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY 47-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY in 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 518 L St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Irma C. Thomas				4. DATE OF DEATH Month 10 - Day 17 - Year 1967			
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/14/23		9. AGE (In years last birthday) yrs. 44		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Wiggins				14. MOTHER'S MAIDEN NAME Olga Noble			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT decedent Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of tonsil with metastases 1450 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 10/13/1967 , to 10/17/1967 , that he (we) last saw the deceased alive on 10/17/1967 , and that death occurred at 11:15AM from causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/17/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-21-67		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM.		23d. LOCATION (City or Town) (County) (State) SUITLAND, MD.	
24. FUNERAL DIRECTOR BARNES & MATTHEWS				ADDRESS WASHINGTON, D.C.		25a. REC'D BY REGISTRAR DATE OCT 23 1967	
				25b. REGISTRAR'S SIGNATURE R Charles Judge			

Prince George

Glenn Dale (local)

Glenn Dale Hospital

Washington, D.C.

310 A St., N.E.

Thomas

O.

James

A

SAVING

WA

USA

Washington, D.C.

unknown

unemployed

Olga Noble

William T. Williams

descendant

unknown

no

Washington, D.C. 20001

10/13/67

11:15am

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10/13/67

Glenn Dale Hospital, Glenn Dale, Md.

Nov. 1967, M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14403				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14408			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 days						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 4682 Homer Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle E. Last Trammell						4. DATE OF DEATH Month Oct. Day 18, Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/10/05		9. AGE (In years lost birthday) yrs. 62		IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER				10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VANCE TRAMMELL						14. MOTHER'S MAIDEN NAME OLE HOGAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 577-10-8202		17. INFORMANT Sadie Trammell		Address 4682 Homer Ave Suitland, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident. DUE TO (b) Acute myocardial Infarction. DUE TO (c) Arteriosclerotic Cardiovascular Disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 8, 19 67 , to Oct. 18, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 18, 19 67 , and that death occurred at 8:45AM , from causes and on the date stated above.											
22a. SIGNATURE Tomas J. Hernandez						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Oct. 18, 1967			
22c. PHYSICIAN'S NAME (Type) Tomas J. Hernandez, M. D.						22d. ADDRESS Prince Georges General Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 21 1967		23c. NAME OF CEMETERY OR CREMATORY WASH. NATIONAL CEM				23d. LOCATION (City or Town) (County) (State) SUITLAND MARYLAND			
24. FUNERAL DIRECTOR W.W. Chambers Co						ADDRESS 5801 CLEVELAND AVE RIVERDALE		REC'D BY REGISTRAR OCT 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

Prison Doctor

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

CERTIFICATE OF DEATH

14410

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>VIRGINIA</u> b. COUNTY <u>HERNDON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colonial Beach</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nsg Home</u>		d. STREET ADDRESS <u>213 DENNESON</u>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>E.</u> Last <u>VANDEUSEN</u>		4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-72</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Health</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A. VAN DEUSEN</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. HITCHENS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. ANN F. VANDEUSEN</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>A. S. H. D.</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>67</u> to <u>10/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/23</u> , 19 <u>67</u> , and that death occurred at <u>8:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Henry J Palacios</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY J PALACIOS</u>		22d. ADDRESS <u>8000 Indian Head Hwy Crofton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/17/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Herndon Virginia</u>
24. FUNERAL DIRECTOR <u>Funeral Home - 2847 Wilson Blvd Va</u>		25a. REC'D BY REGISTRAR <u> </u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

OCT 18 1967

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park 16-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						d. STREET ADDRESS 4614 Drexel Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank Vrana Jr						4. DATE OF DEATH Month Day Year October 20, 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/5/11		9. AGE (In years last birthday) yrs. 56		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (County & State, or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank Vrana						14. MOTHER'S MAIDEN NAME Stella Sykora					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Anne Vrana College Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Metastatic Ca of the brain DUE TO (c) Ca of the lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 5, 1967 , to Oct 20, 1967 , that (I) (we) last saw the deceased alive on Oct 20, 1967 , and that death occurred at 2:05 PM , from causes on and on the date stated above.											
22a. SIGNATURE John R. Lilly, M. D.						22b. DATE SIGNED 10-21-67					
22c. PHYSICIAN'S NAME (Type) John R. Lilly, M. D.						22d. ADDRESS 4410 74th Ave. Bellmead, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Oct 24, 1967		23c. NAME OF BURIAL OR CREMATORY Ft Lincoln Crematory				23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

14411

1-11-11

RECEIVED BY THE OFFICE OF THE ATTORNEY GENERAL

EXHIBIT 11

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14408			
CERTIFICATE OF DEATH			
14412			
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson Heights	
c. LENGTH OF STAY IN 1b 5 days		d. STREET ADDRESS 1006 65th Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Walker		4. DATE OF DEATH Month Oct. Day 14 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 Oct., 1967
9. AGE (In years lost birthday) yrs. 5		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W Edgar Walker		14. MOTHER'S MAIDEN NAME Victoria Furr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (720 grams) 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Atelectasis of lungs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 9, 1967 to Oct. 14, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 14, 1967 , and that death occurred at 4:50 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Hugh Clark</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Hugh Clark, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11-14-67	
23c. NAME OF CEMETERY OR CREMATORY Prince George's Hospital		23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland	
24. FUNERAL DIRECTOR HARRY W. PENN JR.		25a. RECEIVED BY REGISTRAR NOV 7 1967	
25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		25c. REGISTRAR'S NAME James Judge	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

14407

14413

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b about 2 1/2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David First Middle Last		4. DATE OF DEATH 10 22 1967 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-23-43
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) auto mechanic		10b. KIND OF BUSINESS OR INDUSTRY mechanics	9. AGE (In years lost birthday) 24 yrs.
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Roger Ward		14. MOTHER'S MAIDEN NAME Elissa Stauted	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) perforating gunshot wound of abdomen DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shot by policeman during arrest attempt	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3:05pm p.m. 10-19 1967	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4100 Powdermill Rd., Beltsville, P.G.	20f. (City or town) (County) (State) Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John A. Kehoe		22. DATE SIGNED 10-22-67	
EXAMINER'S NAME (Type) John A. Kehoe M.D., Riverdale, Maryland		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 10/24/1967	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND
24. FUNERAL DIRECTOR HYSONG'S FUNERAL HOME		25a. REC'D BY REGISTRAR OCT 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with this form. PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11101

RECEIVED

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1961 OCT 1 10 11 AM

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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14408

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14414

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Conn. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Haven	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 338 Orange St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Gen. Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Josephine Carroll Wardell		4. DATE OF DEATH Month 10 Day 4 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 May 1896
9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress
11. BIRTHPLACE (State or foreign country) New Haven, Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Carroll		14. MOTHER'S MAIDEN NAME Mary Mannix	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Sisk F.H., New Haven, Conn.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aneurysm of thoracic and abdominal aorta - over 1 year.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 10-5-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/7/67	23c. NAME OF CEMETERY OR CREMATORY St. Lawrence Cem.	23d. LOCATION (City or Town) (County) (State) New Haven, Conn.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, 5130 Wis. Ave. NW		25a. REC'D BY REGISTRAR OCT 9 1967	
Address Washington, D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN 1b 2 Mos., 14 Da	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PINE VIEW GARDENS, CLINTON MD		d. STREET ADDRESS Box 5	
3. NAME OF DECEASED (Type or print) First LAURA Middle Rebecca Last WATSON		4. DATE OF DEATH Month October Day 19 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-25
9. AGE (In years lost birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Smith		14. MOTHER'S MAIDEN NAME Josephine Boswell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-22-024	
17. INFORMANT Joseph C. Watson-Same as Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility (c) 3 Day		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-5 , 19 67 , to 10-19 , 19 67 , that (I) (we) last saw the deceased alive on 10/19-67 , and that death occurred on 2:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Alfred R. Lapin, MD		22b. DATE SIGNED 10/19/67	
22c. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD		22d. ADDRESS CLINTON, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/21/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	23d. LOCATION (City or Town) (County) (State) Upper Marlboro Md.
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR DATE OCT 30 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

14410

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14416

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 12002 Gordon Ave.,	
3. NAME OF DECEASED (Type or print) Oliver W Weekley		4. DATE OF DEATH 10-11-67	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Mar., 1925
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Officer		11b. KIND OF BUSINESS OR INDUSTRY Pro Geo County	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME James H Weekley		14. MOTHER'S MAIDEN NAME Mary B Wright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W W 11		16. SOCIAL SECURITY NO. 578 22 0721	
17. INFORMANT Lois Weekley		Address Beltsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Minutes Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		22. DATE SIGNED 1-15-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR Oct 19 1967	
Address Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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UNITED STATES DEPARTMENT OF JUSTICE

Washington, D.C.

January 1, 1951

TO THE ATTORNEY GENERAL

FROM THE DIRECTOR, FBI

RE: [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14417											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON 47-3					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PRINCE GEORGE'S HOSPITAL						d. STREET ADDRESS 5061 NEW HAMPSHIRE AV				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH WELCH			4. DATE OF DEATH Month Day Year Oct 16, 1967								
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct 29 1892		9. AGE (in years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE, BOOK KEEPER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ILLINOIS			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME ENGLEBERT BECKER						14. MOTHER'S MAIDEN NAME CAROLINE HAASLE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 359 160185		17. INFORMANT MRS RUTH L. VEITH		Address 3204 TOLEDO PLACE APT HYATTSVILLE, MD. 202			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c) Atherosclerosis of Coronary artery										INTERVAL BETWEEN ONSET AND DEATH under 1 day yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1965, to 10-16, 1967, that (I) (we) last saw the deceased alive on 10-13 1967, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE Donald C. Edgren						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-19-67			
22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN						22d. ADDRESS Agathsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION			23b. DATE THEREOF Oct 18, 1967		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY			23d. LOCATION (City, town or county) (State) COLMAR MANOR, MD			
24. FUNERAL DIRECTOR W.W. CHAMBERS						ADDRESS 60 RIVERDALE, MD		25a. REC'D BY REGISTRAR OCT 20 1967		25b. REGISTRAR'S SIGNATURE Michael J. Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 of 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in the space provided in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14412 CERTIFICATE OF DEATH 14418

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> c. LENGTH OF STAY IN 1b <u>16-1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Magnolia Gardens</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> d. STREET ADDRESS <u>8610 MAPLE AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James Edward Wildman SR.</u> First Middle Last 4. DATE OF DEATH <u>Oct 5 1967</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>25 Nov. 1883</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>WESTERN UNION</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>James G. Wildman</u> 14. MOTHER'S MAIDEN NAME <u>Dennison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>ELIZABETH WILDMAN DAU. SAME AS #2</u> 17. INFORMANT Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ch. Myocarditis</u> 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>Oct 5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct 5</u> , 19 <u>67</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert S. McCeney</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>ROBERT S. MCCENEY, M. D.</u> <u>402 MAIN ST.</u>				22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. <u>LAUREL MARYLAND 20810</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Collington Pro Geo Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR <u>OCT 9 1967</u> REGISTRAR'S SIGNATURE <u>James J. Judge</u> DATE			

ROBERT J. WILCHES, M.D.

22. 4. 1982

CLASS OF 1948

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 7076 Hanover Parkway	
3. NAME OF DECEASED (Type or print) Clarence Wallace Williams		4. DATE OF DEATH Month 10 Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 April 1914
9. AGE (In years lost birthday) 53 Yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED VETERAN	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 229-12-0653	
17. INFORMANT GEORGE B. WILLIAMS Address 7078 HANOVER PARKWAY, GREENBELT, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4200			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 10-30-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov 2, 1967	23c. NAME OF CEMETERY OR CREMATORY CITY POINT NATIONAL	23d. LOCATION (City or Town) (County) (State) HOPEWELL, VIRGINIA
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD		25a. SIGNED BY REGISTRAR NOV 2 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

1911

STANDARD TIME

1911

STANDARD TIME

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "STANDARD TIME" and "1911" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20 M 1/66

14414				Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14420			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. Ges.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>47 A STREET</u>				d. STREET ADDRESS <u>47 A STREET</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph LOUIS Williams</u>				4. DATE OF DEATH Month Day Year <u>Oct 10 1967</u>							
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1891</u> <u>76</u> yrs.		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>used furniture dealer self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>James Williams</u>				14. MOTHER'S MAIDEN NAME <u>Laura Keith</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW1</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Annie Williams Laurel Md</u>		Address <u>47 A St</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary arteriosclerosis & chronic cardiac failure</u>								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>8-13</u> , 19 <u>67</u> , to <u>10-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-10</u> , 19 <u>67</u> , and that death occurred at <u>8:30 P.M.</u> from causes and on the date stated above.											
22a. SIGNATURE <u>John Pierandrew</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-10-67</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Garage Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Garage Md.</u>					
24. FUNERAL DIRECTOR <u>Walt Canadon Laurel Md</u>				ADDRESS		25. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
				DATE <u>OCT 17 1967</u>							

1-1530

RECORD OF DEATH

1-1530

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
CAUSE OF DEATH		PLACE OF DEATH	
CERTIFICATE NO.		REGISTERED	
SIGNATURE		DATE	
WITNESSES		OFFICIAL	
FAMILY		CITY	
COUNTY		STATE	
ZIP CODE		COUNTRY	

RECEIVED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ON 1-15-30
AT 10:00 AM
OFFICE OF THE REGISTRAR
WASHINGTON, D.C.

VR A15 (4)
25M 1/67

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. CAUSE OF DEATH a. COUNTY, Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Savage	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS Box 24		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blanche H. Williamson		First Middle Last		4. DATE OF DEATH Month October Day 2 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-15	9. AGE (In years lost birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) butler		10b. KIND OF BUSINESS OR INDUSTRY distillery		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Henderson, William		14. MOTHER'S MAIDEN NAME Annie Giles		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Husband/Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocarditis DUE TO (b) Chronic Myocarditis DUE TO (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 3 days 11 yrs 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetic Mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Dec 28, 1956 , to 10/2/67 , 19 67 , that (I) (we) last saw the deceased alive on 10/1 19 67 , and that death occurred at 10:28 A.M. , from causes and on the date stated above.					
22a. SIGNATURE Robert S. McCeney, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ROBERT S. MCCENEY, M. D. 402 MAIN ST.		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 10/5/67	23c. NAME OF CEMETERY OR CREMATORY Memlandridge Memorial Park		23d. LOCATION (City or Town) (County) (State) Laurel Maryland 20810
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR DATE OCT 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10111

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ROBERT S. MCGOWAN, M.D.
12 MAY 1961
LABORATORY, BOSTON

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14416

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14422

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN tb 10 Hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 5209 57th. Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last James Elwood Wilson		4. DATE OF DEATH Month Day Year 10 16 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-1921
9. AGE (In years lost birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Wilson		14. MOTHER'S MAIDEN NAME Maude Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942 to 1962		16. SOCIAL SECURITY NO. 442 14 0915	
17. INFORMANT Marjorie C Wilson		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Following surgery for peritonitis (b) Secondary to trauma - auto accident DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH minutes 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which hit a tree.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:05am 10-10- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5000 block Edmonston Rd, Bladensburg, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 10-17-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 19, 1967	
23c. NAME OF CEMETERY OR CREMATORIUM Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR OCT 20 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

THE UNITED STATES OF AMERICA

IN SENATE, JANUARY 10, 1900.

REPORT OF THE

COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR 1899

AND THE PROCEEDINGS OF THE

LAND OFFICE DURING THE YEAR 1899

AND THE PROCEEDINGS OF THE

LAND OFFICE DURING THE YEAR 1899

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FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20&21 Film 397				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				Item 3 Film G397.2/19/68 JK				14423			
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND								2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 8 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital								d. STREET ADDRESS 919 Lemma Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Paul Charles Wilson				4. DATE OF DEATH Month 10 Day 30 Year 1967											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4-18-1910		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —		11. IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (State or foreign country) Tenn.				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME George Wilson				14. MOTHER'S MAIDEN NAME Rosie Bales											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) W.W.II.				16. SOCIAL SECURITY NO. 413-14-1650				17. INFORMANT (Sister) Address Balto, Md				Mrs Myrtle Pratt, 942 W. Lombard St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma 936.9 DUE TO Trauma. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —												INTERVAL BETWEEN ONSET AND DEATH —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Undetermined														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Undetermined											
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 10-22 19 67				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Undetermined				20f. (City or town) Bowie (County) Pr. Geo. (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 11-2-67											
EXAMINER'S NAME (Type) John Kehoe, M.D.				Address (Street, city, town, or county) Riverdale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 11/6/67		23c. NAME OF CEMETERY OR CREMATORY Roseberry				23d. LOCATION (City or Town) (County) (State) Knox County Tenn.					
24. FUNERAL DIRECTOR W.W. Chambers Co.				ADDRESS 1400 Chapin St. N.W. Wash. DC				25a. REC'D BY REGISTRAR NOV 6 1967				25b. REGISTRAR'S SIGNATURE J. A. Jones			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G394 11/6/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing Home</u>		d. STREET ADDRESS <u>11 Seaton Place N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Daniel</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-15-96</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elevator Operator</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Augusta Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jerry T. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Louise Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>579-40-6646</u>	
17. INFORMANT <u>Mary L. Brown</u>		Address <u>6239 Reservoir Rd., N.W., Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u> DUE TO (b) <u>Myocardial Failure</u> DUE TO (c) <u>Arteriosclerotic Cor. Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>6 mo</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis C.V.A. 1962, Senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a.m. <u>10</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (If (this hospital) attended the deceased from <u>10/12/67</u> to <u>10/27/67</u> , that (I) (we) last saw the deceased alive on <u>10/27/67</u> , and that death occurred at <u>12:05 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Kelvin L. Minchin, M.D.</u>		22b. DATE SIGNED <u>10/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KELVIN L. MINCHIN</u>		22d. ADDRESS <u>6400 MARLBORO PINE SE.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-31-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, P. G., Maryland</u>	
24. FUNERAL DIRECTOR <u>Hall Bros.</u>		25a. REC'D BY REGISTRAR <u>621 Fla. Ave NW</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		NOV 1 1967	

Richard D. Webb

My dear Mr. [illegible]

Little more to be said

(Faint handwritten notes at the bottom of the page)

10/15 / 15.000

10/35/01

KEVIN L. MURPHY, Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G394 10/30/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47-3</u>	
c. LENGTH OF STAY IN Tb		d. STREET ADDRESS <u>2101 16th Street N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>Wolowitz</u> Last <u>Wolowitz</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1878</u>
9. AGE (In years lost birthday) yrs. <u>89</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wolf Wolowitz</u>		14. MOTHER'S MAIDEN NAME <u>Esther</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>266-54-6423</u>	
17. INFORMANT <u>William H. Wolowitz</u>		Address <u>1742 Holly St. N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>GASTRO INTESTINAL HEMORRHAGE</u> DUE TO (c) <u>GASTRIC ULCER</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>10 DAYS</u> <u>10 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>DIABETES MELLITUS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1, 1967</u> to <u>OCT 20, 1967</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>OCT 20, 1967</u> , and that death occurred at <u>8:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel J. N. Sugar</u>		22b. DATE SIGNED <u>OCT 20, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel J. N. Sugar</u>		22d. ADDRESS <u>4637 Eastern Ave. Washington 18, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Old Shalom Island Torah Cen</u>	23d. LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>
24. FUNERAL DIRECTOR <u>B. Danyusky & Sons</u>		25a. REC'D BY REGISTRAR <u>3561-14-8000</u> <u>Wash. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Johnnie Judge</u>		DATE <u>OCT 24 1967</u>	

MEDICAL CERTIFICATION

History of Present Illness

Physical Examination

Diagnosis

Principles of General Hospital

1911-1912

History

Examination

Case

1911-1912

1911-1912

1911-1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14426											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) UNIVERSITY PARK c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4300 TUCKERMAN ST						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) UNIVERSITY PARK d. STREET ADDRESS 4300 TUCKERMAN ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last ALFRED R. YANCEY						4. DATE OF DEATH Month Day Year OCT 11, 1967					
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 MARCH 1904		9. AGE (in years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER				10b. KIND OF BUSINESS OR INDUSTRY BUILDING		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME EDWIN L. YANCEY						14. MOTHER'S MAIDEN NAME EDITH M. THORNTON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 578287156		17. INFORMANT MRS. THEORA A. YANCEY		Address SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized lympho-sarcoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 28, 1967, to Oct 11, 1967, that (I) (we) last saw the deceased alive on Oct 10, 1967, and that death occurred at 4 AM, from the causes and on the date stated above.											
22a. SIGNATURE Don B. Cameron										22b. DATE SIGNED 10-11-67	
22c. PHYSICIAN'S NAME (Type) DON B. CAMERON						22d. ADDRESS MT. RAINIER, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF OCT 14, 1967		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY			23d. LOCATION (City, town or county) (State) CULPEPER, VIRGINIA			
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD.						25a. REC'D BY REGISTRAR DATE OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14421									
14427									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland 20781 b. COUNTY Prince George				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital					d. STREET ADDRESS 6022 44th. Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ezra J. Youmans					4. DATE OF DEATH Month 10 Day 20 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-9-97		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10b. KIND OF BUSINESS OR INDUSTRY Cab Company		11. BIRTHPLACE (County & State, or foreign country) Georgia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Oliver Youmans					14. MOTHER'S MAIDEN NAME Rosella Dickson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO. 212 12 2925		17. INFORMANT Address Wife and Medical Records Department				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC } CARDIO DUE TO AND RHEUMATIC } VASCULAR DISEASE (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS									INTERVAL BETWEEN ONSET AND DEATH ONE MONTH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-25 , 19 67 , to 10-20 , 19 67 , that (I) (we) last saw the deceased alive on 10-20 19 67 , and that death occurred at 8:50 AM, from causes and on the date stated above.									
22a. SIGNATURE C. J. Houmann					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-20-67		
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN					22d. ADDRESS RIVERDALE MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					25a. REC'D BY REGISTRAR OCT 23 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14428

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
c. LENGTH OF STAY IN lb ten hours		d. STREET ADDRESS Rte. 2, Box 153 Contee Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Andrew Zalupsky		4. DATE OF DEATH Month 10 Day 6 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-9-14
9. AGE (In years lost birthday) yrs. 53		10. IF UNDER 1 YEAR Months 16 Days 1	11. IF UNDER 24 HRS. Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laurel	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stanley Zalupsky		14. MOTHER'S MAIDEN NAME Elizabeth Pencook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 351 McCondeless Rd	
17. INFORMANT Mary Sharick Arnold, Pa 15068		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Trauma DUE TO (c) Auto Accident	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH pedestrian struck by car		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) pedestrian struck by car	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:32pm p.m. 10-5 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Route 1, (near) Laurel, P.G., Md.		20f. (City or town) (County) (State) Laurel, P.G., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 10-8-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		23. ADDRESS (Street, city, town, or county) Riverdale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-9-67	
23c. NAME OF CEMETERY OR CREMATORY Sanage Cemetery		23d. LOCATION (City or Town) (County) (State) Sanage, Howard Md.	
24. FUNERAL DIRECTOR De Witt Canalean, Laurel Md		25. REG'D BY REGISTRAR DATE OCT 10 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14423

14429

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2½ months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyattsville Nursing Home		d. STREET ADDRESS 4627 47th St. N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EMMA CADEI ZANDONINI		4. DATE OF DEATH Month Oct. Day 4 Year 19 67	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1877
9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR Months 4 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (County & State, or foreign country) CHiari, Italy 1
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Faustino Cadei	
14. MOTHER'S MAIDEN NAME Maria Maggione		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 579-66-6019		17. INFORMANT Elizabeth M. Zandonini, Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Branchiopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INTERVAL BETWEEN ONSET AND DEATH 22 weeks (c) 2		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis year		20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from 12-23-60 to 9-29-67 , that (I) (we) saw the deceased alive on 9-29-67 , and that death occurred at 4:20 P.M. from causes and on the date stated above.	
22a. SIGNATURE C P Ryland		22b. DATE SIGNED 10-4-67	
22c. PHYSICIAN'S NAME (Type) C P RYLAND		22d. ADDRESS 4400-49th St NW Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/67	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, 5130 Wis. Ave, NW, Wash., D.C.		25a. REC'D BY REGISTRAR DATE OCT 9 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

14-00000

STATE OF TEXAS

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Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #Gaol. 11/6/67 ph

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 57 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 4407 Vanburen St., University Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy D. Zentz		4. DATE OF DEATH Month October Day 24 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/1895
9. AGE (In years lost birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Andrew L Huss		14. MOTHER'S MAIDEN NAME Florence A. Reeder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ezra Monroe Zentz		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5810 IMMEDIATE CAUSE (a) Nutritional cirrhosis of the Liver with DUE TO hepatic failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-15 , 19 67 , to 10/24 , 19 67 , that (I) (we) last saw the deceased alive on 10-23 , 19 67 , and that death occurred at 8:40 M. from causes and on the date stated above.			
22a. SIGNATURE Don B. Cameron		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) Dr. Don B. Cameron		22d. ADDRESS 3503 Perry St., Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR OCT 30 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

